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ABSTRACT

This KIDS COUNT databook is the fifth annual profile examining statewide trends in the well-being of Rhode Island's children. The statistical portrait is based on 30 indicators in 5 areas: (1) family and community (covering child population and children in single-parent families); (2) economic well-being (covering median household income, cost of rent, children in poverty, children in the Family Independence Program, children in families receiving food stamps, and children receiving school breakfast); (3) health (covering children's health insurance; women and children receiving WIC; women with delayed prenatal care; low birth weight infants; infant mortality; children with lead poisoning; births to teens; alcohol, drug, and cigarette use by teens; children with asthma; and additional children's health issues); (4) safety (covering child deaths, teen deaths, homeless children, homeless youth, juveniles referred to family court, and child abuse and neglect); and (5) education (covering infant and preschool child care, children enrolled in Head Start, school-age child care, fourth-grade reading proficiency, children enrolled in special education, high school graduation rate, and teens not in school and not working). The report defines each indicator, describes its significance and trends, provides information on intervention programs, and presents relevant data for the state, each city and town, and an aggregate of the five cities with the highest child poverty

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rates. The report concludes with a description of the methodology and acknowledgements. (EV)

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1999 Rhode Island Kids Count Factbook

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Table of Contents

OVERVIEW 3

FAMILY AND COMMUNITY
- Child Population 6-7
- Children in Single Parent Families 8-9

ECONOMIC WELL-BEING
- Median Household Income 12-13
- Cost of Rent 14-15
- Children in Poverty 16-19
- Children in the Family Independence Program 20-23
- Children Receiving Food Stamps 24-25
- Children Receiving School Breakfast 26-27

HEALTH
- Children's Health Insurance 30-31
- Women and Children Receiving WIC 32-33
- Women with Delayed Prenatal Care 34-35
- Low Birthweight Infants 36-37
- Infant Mortality 38-39
- Children with Lead Poisoning 40-41
- Births to Teens 42-43
- Alcohol, Drug, and Cigarette Use by Teens 44-45
- Children with Asthma 46-47
- Additional Children's Health Issues 48-49

SAFETY
- Child Deaths 52-53
- Teen Deaths 54-55
- Homeless Children 56
- Homeless Youth 57
- Juveniles Referred to Family Court 58-59
- Child Abuse and Neglect 60-63

EDUCATION
- Infant and Pre-School Child Care 66-69
- Children Enrolled in Head Start 70-71
- School-Age Child Care 72-73
- Fourth-Grade Reading Proficiency 74-75
- Children Enrolled in Special Education 76-77
- High School Graduation Rate 78-79
- Teens Not in School and Not Working 80-81

METHODOLOGY 84

ACKNOWLEDGEMENTS 85-88

Overview

8

Past, Present, Future

Tell me, tell me, smiling child,
What the past is like to thee?
'An Autumn evening soft and mild
With a wind that sighs mournfully.'

Tell me, what is the present hour?
'A green and flowery spray
Where a young bird sits gathering its power
To mount and fly away.'

And what is the future, happy one?
'A sea beneath a cloudless sun;
A mighty, glorious, dazzling sea
Stretching into infinity.'

—Emily Brontë

Overview

The *1999 Rhode Island KIDS COUNT Factbook* is the fifth annual profile of the well-being of children in Rhode Island. The annual Factbook is an important tool for planning and action by community leaders, policy makers, advocates, and others working toward changes that will improve the quality of life for all of Rhode Island's children.

The annual Factbook tracks progress across five areas of child well-being. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his family and community affects his school performance; a child's economic security affects her health and education. The *1999 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide children's policy, programs for children and families, and individual service on behalf of children.

The *1999 Rhode Island KIDS COUNT Factbook* provides a statistical portrait of the status of Rhode Island's children. Information is presented for the state of Rhode Island, each city and town, and an aggregate of the five cities with the highest child poverty rates. These cities — referred to as the "core cities" in the Factbook — are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

By examining the best available data statewide and in Rhode Island's 39 cities and towns, Rhode Island KIDS COUNT provides an information base that can result in more effective policy and community action on behalf of children. The *1999 Rhode Island KIDS COUNT Factbook* examines thirty indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The most current and reliable data available are presented for each indicator.

Healthy Communities

The Factbook provides community-level information on each indicator in order to emphasize the significance of the surrounding physical, social, and economic environment in shaping outcomes for children. Communities and neighborhoods do matter — the actions of community leaders, parents, individuals, businesses, government leaders, and elected officials greatly influence children's chances for success and the challenges they will face. Tracking changes in selected indicators can help communities to set priorities, identify strategies to reverse negative trends, and monitor progress.

Family Economic Well-being

Children most at risk of not achieving their full potential are children in poverty. Despite overall economic growth in the past decade, many Rhode Island families have experienced income losses since the late 1980s. The child poverty rate in Rhode Island has increased from 14% in 1990 to 18% in 1996. The high costs of child care, health care and housing make it difficult for many families with incomes above the official poverty level to make ends meet. Child care subsidies, health care subsidies, affordable housing, and tax policies that support working families are critical tools to ensure the economic well-being of Rhode Island families.

Early Investments

Improving outcomes for children of all ages requires investments in young children and their families. Many of the difficult and costly problems faced by adolescents can be prevented by providing children with a better start in life. Access to health care, quality child care options, economic security, affordable housing, nurturing environments for children, and supportive communities for parents have been shown to improve child and adolescent outcomes.

Family and Community

12

A Song of Greatness

When I hear the old men
Telling of heroes,
Telling of great deeds
Of ancient days,
When I hear them telling,
Then I think within me
I too am one of these.

When I hear the people
Praising great ones,
Then I know that I too
Shall be esteemed,
I too when my time comes
Shall do mightily.

—A Chippewa Indian song
Transcribed by Mary Austin

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Child Population

DEFINITION

Child population is the percentage of the total population that is under the age of 18.

SIGNIFICANCE

In 1996, there were 220,938 Rhode Island children under age 18.[1] Twenty-three percent of the Rhode Island population was under age 18 in 1996.[2] One household in four has a school-age child. Over the next decade the number of Rhode Island teenagers will grow by 20%, while the number of younger children ages birth to 12 will drop by 2%.[3]

Rhode Island, and the U.S. as a whole, will continue to grow more diverse into the next century. The Asian population is the fastest-growing group in all regions of the United States. Nationally, the Hispanic population is projected to increase rapidly over the 1995 to 2025 projection period, accounting for 44% of the growth in the nation's population. The Hispanic origin population is the second fastest-growing population, after Asians, in every region.[4]

Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. Between 1995 and 2005 in Rhode Island the number of white non-Hispanic children is projected to decrease by 7%; the number of Black children will increase by 18%; Native American children will increase by 62%; Asian children will increase by 61%; and Hispanic children will increase by 51%.[5]

According to the 1990 Census, 13,500 of Rhode Island's children were born outside the U.S., including 5,400 Hispanic children and 3,300 Asian children.[6] Many immigrant children and children of recent immigrants are proficient in a language other than English. In 1990, more than 25,000 Rhode Island children age 5 to 17 spoke a language other than English at home.[7]

Rhode Island's Children, 1996

By Age

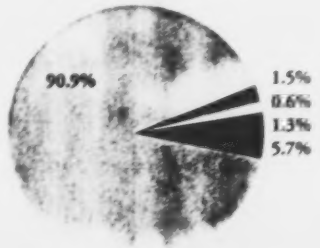
5.9%	Less than age 1
27.9%	Ages 1 to 5
32.5%	Ages 6 to 11
33.6%	Ages 12 to 17

By Family Structure

67.6%	Two Parents
27.5%	Mother Only
2.7%	Father Only
1.7%	Other

By Race*

5.7%	Black
90.9%	White
1.5%	Asian/Pacific Islander
0.6%	American Indian
1.3%	Other



**Hispanic children may be included in any race category. 11.1% of Rhode Island's 220,938 children are of Hispanic origin.*

Source: U.S. Bureau of the Census, Current Population Survey, 1994 to 1998 average.

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Table 1.

Child Population, Rhode Island, 1990

CITY/TOWN	TOTAL POPULATION	CHILDREN UNDER AGE 18 N	CHILDREN UNDER AGE 18 %	% MINORITY CHILDREN UNDER AGE 18
Barrington	15,849	3,912	24.7%	2.4%
Bristol	21,625	4,380	20.3%	4.4%
Burrillville	16,230	4,479	27.6%	0.8%
Central Falls	17,637	4,810	27.3%	49.3%
Charlestown	6,478	1,575	24.3%	5.3%
Coventry	31,083	7,626	24.5%	2.4%
Cranston	76,060	14,673	19.3%	8.1%
Cumberland	29,038	6,427	22.1%	3.4%
East Greenwich	11,865	2,913	24.6%	5.1%
East Providence	50,380	10,657	21.2%	12.1%
Exeter	5,461	1,521	27.9%	2.6%
Foster	4,316	1,185	27.5%	2.0%
Glocester	9,227	2,526	27.4%	1.6%
Hopkinton	6,873	1,839	26.8%	3.4%
Jamestown	4,999	1,123	22.5%	2.8%
Johnston	26,542	5,332	20.1%	3.9%
Lincoln	18,045	3,890	21.6%	3.6%
Little Compton	3,339	750	22.5%	2.7%
Middletown	19,460	4,676	24.0%	11.2%
Narragansett	14,985	2,869	19.1%	4.4%
Newport	28,227	5,756	20.4%	19.2%
New Shoreham	836	163	19.5%	3.1%
North Kingstown	23,786	6,076	25.5%	5.2%
North Providence	32,090	5,655	17.6%	5.9%
North Smithfield	10,497	2,332	22.2%	2.4%
Pawtucket	72,644	16,719	23.0%	21.2%
Portsmouth	16,857	4,175	24.8%	4.3%
Providence	160,728	37,972	23.6%	55.5%
Richmond	5,351	1,565	29.2%	3.6%
Scituate	9,796	2,426	24.8%	1.4%
Smithfield	19,163	3,898	20.3%	2.6%
South Kingstown	24,631	4,770	19.4%	7.8%
Tiverton	14,312	3,166	22.1%	1.7%
Warren	11,385	2,452	21.5%	2.7%
Warwick	85,427	18,322	21.4%	3.4%
Westerly	21,605	4,988	23.1%	3.0%
West Greenwich	3,492	915	26.2%	1.6%
West Warwick	29,268	6,560	22.4%	4.8%
Woonsocket	43,877	10,617	24.2%	14.5%
Core Cities	*323,113*	*75,874*	*23.5%*	*39.1%*
Remainder of State	*680,351*	*149,816*	*22.0%*	*4.9%*
Rhode Island	*1,003,464*	*225,690*	*22.5%*	*16.4%*

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Minority is defined here by the race and ethnicity groups used in the 1990 Census of Population and includes children under age 18 identified by 1990 Census data as Black, Asian, Native American, and/or Hispanic.

The denominator is the total number of children under age 18 according to the 1990 Census of Population.

References for Indicator

[1] U.S. Bureau of the Census, Current Population Survey, 1994 to 1998.

[2] *1998 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1998). Baltimore, MD: The Annie E. Casey Foundation.

[3] *Current Populations Report* (1997). "Population Projections: States, 1995-2025." Washington, DC: US Bureau of the Census.

[4] *1997 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1997). Baltimore, MD: The Annie E. Casey Foundation.

[5] U.S. Bureau of the Census, 1990 Census of Population, Five-Percent Public Use Microdata Sample (PUMS).

[6] *1995 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1995). Baltimore, MD: The Annie E. Casey Foundation.

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Children in Single Parent Families

DEFINITION

Children in single parent families is the percentage of children under age 18 who live in families headed by a person —male or female— without a spouse present in the home. These numbers include "own children" defined as never-married children under 18 who are related to the family head by birth, marriage, or adoption.

SIGNIFICANCE

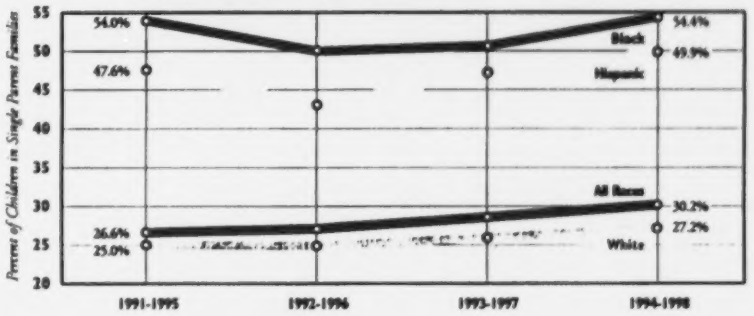
Although most Rhode Island children live with two parents, 30% lived in a single parent family in 1996.[1] The proportion of children living with one parent has almost doubled since 1970. The increase in single parent families over the past three decades has occurred across all races and income levels.[2] According to the Center for Demographic Policy in Washington DC, sixty percent of all children in the United States will spend some time in a single parent family before reaching age 18.[3] In 1997 in Rhode Island, 36.5% percent of all births were to unmarried women.[4]

Children in single parent families are at increased risk of living in poverty when compared to children in two-parent families.[5] Nearly 75% of American children growing up in single parent families experience poverty for some period in their first ten years — compared to 20% of children in two-parent families.[6]

In 1996, the average household income in Rhode Island for two-parent families with children was $60,735 compared to $33,658 for single-parent families headed by a man and $23,943 for single-parent families headed by a woman.[7] In 1996, just under half of Rhode Island's single parent families with children were living below the poverty line.[8] When the single parent is a woman, the risk of falling into poverty is greater, due to factors such as the wage gap between men and women, limited education and training for higher-wage jobs, and inadequate child support.[9] In 1995 in Rhode Island, one in three female-headed families with children received child support.[10]

Compared with teenagers who grow up with both parents at home, adolescents who have lived apart from one of their parents during some period of their childhood are twice as likely to drop out of school, twice as likely to have a child before age 20, and one and a half times more likely to be out of school and out of work in their teens and early twenties. These effects are found regardless of race and maternal education.[11]

Children in Single Parent Families, by Race/Ethnicity, Rhode Island, 1991-1998



Note: Percentages are calculated within each race and ethnic group.

◆ **Between 1991 and 1998, the percentage of Rhode Island children living in a single parent household increased from 26.6 percent to 30.2 percent.**

Source: U.S. Bureau of the Census, Current Population Surveys, 1991 to 1995 average, 1992 to 1996 average, 1993 to 1997 average, and 1994 to 1998 average.

Family and Community Assets Influence Youth Success

◆ **Youth who thrive in single parent families are almost twice as likely as those who do not to report feeling support from their family, turning to a parent for social support, having a parent involved in schooling, and having explicit parental standards.**

◆ **Many of the differences between single-parent youth who thrive and those who do not point toward a positive family support system; supportive, quality schools; friends who are a positive influence; involvement in extracurricular activities; and, involvement in religious institutions.**

Source: Benson, P. L., and E. C. Roehlkepartain (1993). *Youth in Single Parent Families Risk and Resiliency.* Minneapolis, MN: The Search Institute.

Table 2

Children's Living Arrangements, Rhode Island, 1990

CITY/TOWN	TOTAL FAMILY HOUSEHOLDS WITH CHILDREN UNDER 18	NUMBER OF CHILDREN UNDER 18 YEARS: TWO-PARENT FAMILY N	TWO-PARENT FAMILY %	SINGLE PARENT FAMILY N	SINGLE PARENT FAMILY %
Barrington	2,835	3,514	94.4%	207	5.6%
Bristol	2,300	3,660	88.9%	457	11.1%
Burrillville	2,314	3,824	87.2%	560	12.8%
Central Falls	2,373	2,859	61.7%	1,778	38.3%
Charlestown	833	1,244	83.0%	254	17.0%
Coventry	3,979	6,290	87.2%	920	12.8%
Cranston	7,911	11,360	81.2%	2,622	18.8%
Cumberland	3,491	5,551	90.2%	604	9.8%
East Greenwich	1,609	2,521	88.3%	335	11.7%
East Providence	5,766	7,950	81.7%	1,776	18.3%
Exeter	768	1,278	90.6%	132	9.4%
Foster	591	988	88.2%	132	11.8%
Glocester	1,320	2,036	88.6%	261	11.4%
Hopkinton	930	1,557	90.2%	170	9.8%
Jamestown	623	907	83.4%	181	16.6%
Johnston	2,851	4,229	81.7%	945	18.3%
Lincoln	2,181	3,210	86.1%	518	13.9%
Little Compton	420	612	89.7%	70	10.3%
Middletown	2,429	3,774	85.1%	659	14.9%
Narragansett	1,551	2,227	85.2%	387	14.8%
Newport	3,086	3,569	65.0%	1,920	35.0%
New Shoreham	97	149	88.7%	19	11.3%
North Kingstown	3,299	4,943	85.1%	864	14.9%
North Providence	3,115	4,563	86.6%	706	13.4%
North Smithfield	1,284	1,935	91.1%	188	8.9%
Pawtucket	8,957	11,266	73.9%	3,976	26.1%
Portsmouth	2,429	3,749	91.7%	339	8.3%
Providence	17,948	19,292	56.2%	15,054	43.8%
Richmond	791	1,344	94.9%	72	5.1%
Scituate	1,275	2,079	90.1%	228	9.9%
Smithfield	2,095	3,324	91.0%	330	9.0%
South Kingstown	2,603	3,681	81.8%	819	18.2%
Tiverton	1,727	2,477	84.0%	472	16.0%
Warren	1,356	1,880	83.8%	364	16.2%
Warwick	9,505	14,477	83.6%	2,835	16.4%
Westerly	2,746	4,071	85.7%	680	14.3%
West Greenwich	464	715	86.0%	116	14.0%
West Warwick	3,529	4,711	77.3%	1,386	22.7%
Woonsocket	5,630	6,850	68.6%	3,140	31.4%
Core Cities	***58,014***	***43,836***	***62.8%***	***25,868***	***37.1%***
Remainder of State	***80,217***	***120,830***	***85.4%***	***20,608***	***14.6%***
Rhode Island	***118,231***	***164,666***	***78.0%***	***46,476***	***22.0%***

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 18 according to the 1990 Census of Population.

References for Indicator

[1,2] U.S. Bureau of the Census, Current Population Survey, 1994 to 1998 average.

[2] U.S. Bureau of the Census, Census of Population, 1970, 1980, 1990.

[3] Hodgkinson, Harold L., *A Demographic Look at Tomorrow* (1992). Washington, DC: Institute for Educational Leadership, Center for Demographic Policy.

[4] Rhode Island Department of Health, Division of Family Health, Universal Newborn Screening Database, 1997.

[5] Horn, Wade (1995). *Father Facts*. Lancaster, PA: National Fatherhood Initiative.

[6] Corcoran, M.E. & Chaudry, A. (1997). "The Dynamics of Childhood Poverty" in *The Future of Children, Children and Poverty*, Vol. 7, No. 2. (Summer/Fall 1997). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[10] *1998 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1998). Baltimore, MD: Annie E. Casey Foundation.

[11] McLanahan, S. and G. Sandefur, *Growing Up With a Single Parent* (1994) as quoted in *Kids Count Special Report - When Teens Have Sex: Issues and Trends* (1999). Baltimore, MD: Annie E. Casey Foundation.

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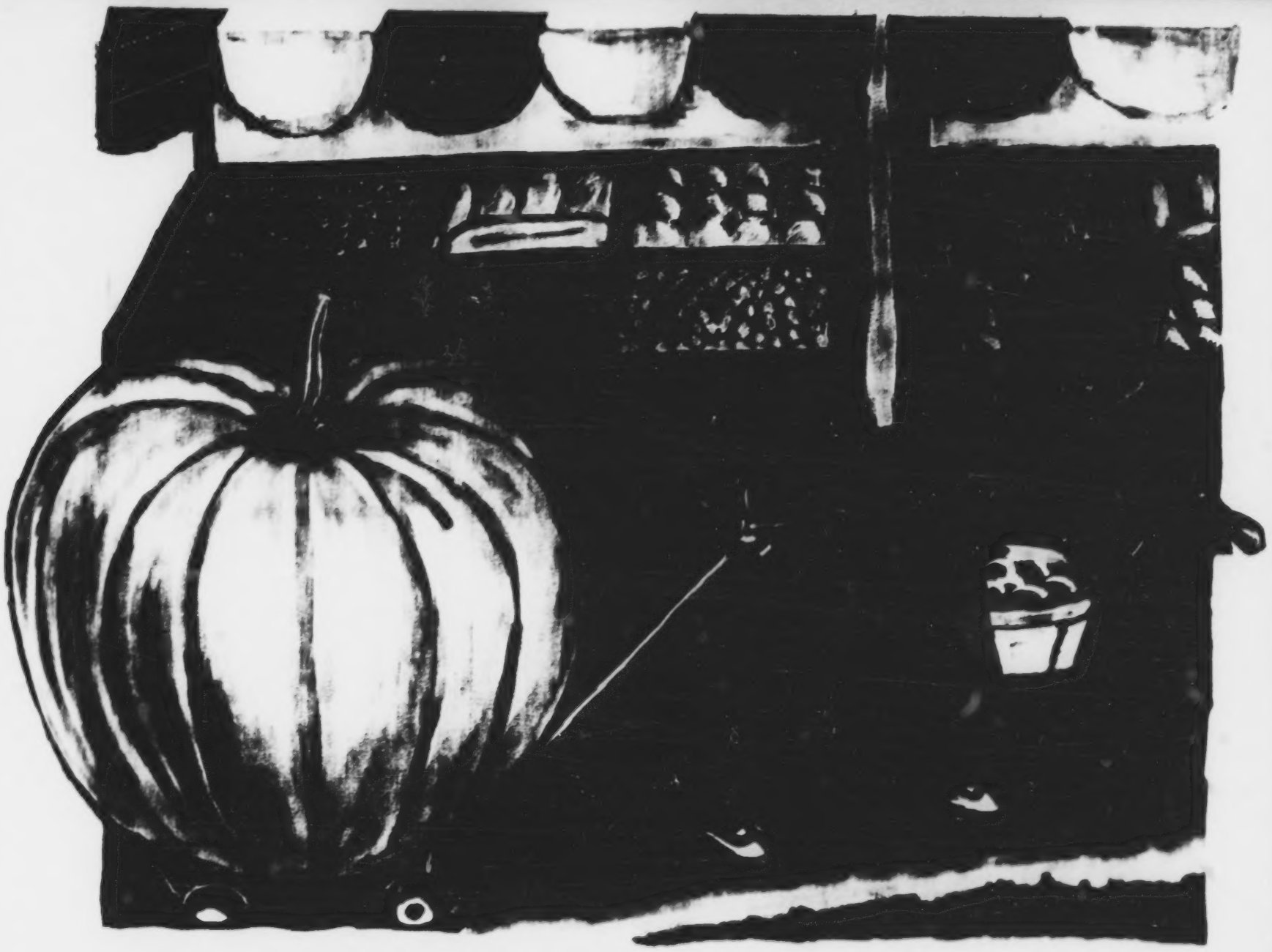
Swift Things Are Beautiful

Swift things are beautiful:
Swallows and deer,
And lightning that falls
Bright-veined and clear,
Rivers and meteors,
Wind in the wheat,
The strong-withered horse,
The runner's sure feet.

And slow things are beautiful:
The closing of day,
The pause of the wave
That curves downward to spray,
The ember that crumbles,
The opening flower,
And the ox that moves on
In the quiet of power.

— Elizabeth Coatsworth



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Median Household Income

DEFINITION

Median household income is the median annual income for Rhode Island households. The median income is the dollar amount which divides the income distribution into two equal groups — half with income above the median and half with income below the median.

SIGNIFICANCE

The median household income provides one measure of the ability of Rhode Island's families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. As the economy shifts to low-paying jobs without benefits or higher-paying jobs that demand advanced education and skills, it is increasingly difficult for many families with children to make ends meet. In 1996, one-half of all Rhode Island families with children earned less than $41,949 and one-half earned more.[1] Nearly one in three households with children had a household income less than $25,000.[2]

Wages and earnings at the lowest end of the labor market — primarily low-skilled workers — have collapsed over the past two decades. The hourly wage rate for a man with a high school degree has fallen in real dollars by about 30% since the early 1970s.[3] For men working full-time year-round, wages in 1997 were $1,500 below 1989 levels.[4] Women's earnings are below those for men in every occupational category for full-time, year-round workers.[5]

Median household income increases with each higher level of education. In the U.S. in 1996, men with at least a college degree had a median family income 2.7 times the median for men who did not complete high school. Median family income for women with a college degree was three times as high as the median for women without a high school diploma.[6]

Several fundamental changes in the U.S. economy have led to stagnating wages among low and middle-income workers. The manufacturing sector, which once provided relative prosperity for a broad middle class of unskilled and semi-skilled workers, is being replaced by low-paying service sector jobs.[7] In Rhode Island between 1986 and 1996, the number of service jobs increased by 33% while the number of manufacturing jobs decreased by 30%.[8] Of Rhode Island working parents with low hourly earnings, 41% work in service jobs, 24% are in retail trade, and 23% are in manufacturing.[9]

Income Trends among Families with Children, Rhode Island, 1986 and 1995

INCOME GROUP	AVERAGE INCOME IN 1986	AVERAGE INCOME IN 1995	PERCENT CHANGE IN INCOME (ADJUSTED FOR INFLATION)
HIGHEST FIFTH OF FAMILIES	$98,470	$111,020	+13%
MIDDLE FIFTH OF FAMILIES	$46,260	$42,590	-8%
LOWEST FIFTH OF FAMILIES	$11,290	$9,910	-12%

Source: Lazin, K. & McNichol, E. (1997). *Pulling Apart: A State-By-State Analysis of Income Trends*. Washington, DC: Center on Budget and Policy Priorities. The 1986 figures represent 1985-1987 data from the Current Population Survey; the 1995 figures represents 1994-1996 data from the Current Population Survey.

◆ Rhode Island is one of 23 states in which high-income families had income gains over the past decade while middle-income and low-income families had income losses.[10]

◆ Despite the increase in real wages that began in 1996, the wages of many middle-income and lower-income families have not returned to 1989 levels. Wage declines over the past decade have been worst among entry level workers. Between 1989 and 1997, real hourly wages for entry-level positions fell 7.4% among men and 6.1% among women.[11]

◆ Recent increases in median family income are largely the result of increases in total work hours — an additional six weeks annually for the typical family since 1989. Families have increased their income either by more family members working and/or by working more hours each year.[12,13]

◆ The stock-market boom has had little impact on the majority of Americans because most working families own little or no stock. In 1995, almost 60% of households owned no stock in any form, including mutual funds and defined-contribution pension plans. Less than one-third of households had stock holdings greater than $5,000.[14]

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Child Support Affects Family Income

♦ The failure of an absent parent to pay child support has significant economic consequences for a parent raising a child or children alone.

♦ 88,963 Rhode Island children are currently in the State's Child Support Enforcement System. Of these, 18,682 (21%) Rhode Island children have not yet had paternity established and therefore have no court order establishing how much is owed. Court orders for child support require the establishment of paternity.

♦ Even when there is a child support agreement in place, child support payments tend to be low and unreliable. Of Rhode Island absent parents under court order, only 40% make child support payments on time and in full.

♦ As of December 31, 1998, in Rhode Island, the amount past due on court-ordered child support totaled $240 million dollars.

Source: RI Department of Administration/Division of Taxation Child Support Enforcement, December 1998.

Child Support Payment and Enforcement

♦ The ultimate goal of the child support enforcement system is to collect money from non-custodial parents so that their children can have adequate financial security as they grow up. For this to happen, paternity must be established, a support order must be entered, and the money must be collected.

♦ Families receiving RIte Care, Medicaid benefits, and/or cash assistance through the Family Independence Program are required to cooperate with their state's child support enforcement agency. Other families may request these services.

Table 3.

Median Household Income, Rhode Island, 1990

CITY/TOWN	MEDIAN INCOME
Barrington	$53,058
Bristol	$34,165
Burrillville	$37,156
Central Falls	$18,617
Charlestown	$36,040
Coventry	$37,230
Cranston	$34,528
Cumberland	$40,683
East Greenwich	$50,896
East Providence	$31,007
Exeter	$38,179
Foster	$40,795
Glocester	$40,000
Hopkinton	$36,737
Jamestown	$41,518
Johnston	$32,596
Lincoln	$37,082
Little Compton	$41,187
Middletown	$35,228
Narragansett	$35,545
Newport	$30,534
New Shoreham	$31,471
North Kingstown	$40,419
North Providence	$32,321
North Smithfield	$41,449
Pawtucket	$26,541
Portsmouth	$42,474
Providence	$22,147
Richmond	$40,975
Scituate	$45,170
Smithfield	$42,523
South Kingstown	$36,481
Tiverton	$36,170
Warren	$31,637
Warwick	$35,786
Westerly	$34,844
West Greenwich	$41,250
West Warwick	$31,625
Woonsocket	$25,363
Core Cities	***NA***
Remainder of State	***NA***
Rhode Island	***$32,181***

Note to Table

In Rhode Island in 1996, the median household income for all households was $42,896 according to the U.S. Bureau of the Census, Current Population Survey, 1994-1998 average. Updated data are not available at the city and town level.

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population, 1989 dollars. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

U.S. Bureau of the Census, Current Population Survey, 1994 to 1998 average.

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Cost of Rent

DEFINITION

Cost of rent is the percentage of income needed by a low-income renter to cover the average cost of rent, including heat. Rent burdens over 30% are considered unaffordable.[1] A low-income renter is defined as income 30% below the 1998 median renter income.[2]

SIGNIFICANCE

Inadequate, costly, or crowded housing has a negative impact on children's health, safety, education, and emotional well-being.[3] Housing that costs more than one-third of a family's income is considered to be unaffordable. Families paying higher percentages of their income for housing are likely to go without other basic necessities such as food and clothing in order to pay their rent (or mortgage) and utilities. Any interruption in income or unexpected expense can place families at risk of eviction, doubling-up with family members, or homelessness.[4] Children who move frequently are more likely to be absent from school, to fall behind in their school work, and to drop out of high school.[5,6] Children living in substandard housing are more at risk for injuries, lead poisoning, asthma, and malnutrition.[7]

Much of the state's rental housing stock is more than fifty years old. Many of the units that might be affordable to a low-income family are in need of repair. Housing and building code violations — including roach and rodent infestation, lead exposure, faulty wiring, inadequate heating systems, and unsanitary plumbing problems— disproportionately affect low-income households.

While substandard housing is a problem in some neighborhoods, affordability is increasingly the primary problem faced by low-income families.[8] The need for housing assistance among low-income families has increased while public subsidies and affordable units in the private rental market have decreased. In 1995 in the U.S., only about one-third of renter households with incomes below the poverty line received a housing subsidy from the federal, state, or local government.[9] As of December 1998 in Rhode Island, 31% of households enrolled in the Family Independence Program were receiving housing assistance.[10]

Affordable Rents for Selected Income Levels, Rhode Island, 1998

Income Level	Annual Income 1998	Affordable Rent (30% of Income)
Median-Income Renter	$25,493	$637
Low-Income Renter	$17,845	$446
Poverty Level Family of Three	$13,650	$341
FIP Cash Assistance plus Food Stamps	$10,596	$265

◆ In 1998, the average rent for a two-bedroom apartment in Rhode Island was $613, including heat. This rent is affordable to a full-time year-round worker earning at least $11.50 per hour.

Source: Rhode Island Housing, January 1999. Calculations by Rhode Island KIDS COUNT.

Shortage of Affordable Housing

◆ Between 1978 and 1995, the percentage of U.S. households with children with a cost burden (paying more than 30% of their income for housing) rose from 15% to 28%.[11]

◆ Housing affordability problems are most likely among families with incomes below 150% of poverty (i.e. income less than $24,675 for a family of four).[12] In 1996, almost one in three Rhode Island families with children under age 18 had an annual income below $25,000.[13]

◆ In Rhode Island, there are nearly two low-income renters for every low-rent unit. Data from the 1995 American Housing Survey indicate that the shortage of affordable housing for low-income renters is wider than ever before. Since the late 1980s, the number of low-cost units has decreased and the number of low-income families has increased.[14]

◆ Rhode Island has among the highest housing costs in the country. When poverty rates are adjusted to account for housing costs, the Rhode Island poverty rate increases and the poverty rate ranks in the highest third (17th) in the country.[15]

Table 4. **Cost of Rental Housing for Low-Income Families, Rhode Island, 1998**

CITY/TOWN	1998 AVERAGE RENT 2-BEDROOM	1998 LOW-INCOME RENTER INCOME	% INCOME NEEDED FOR RENT LOW-INCOME RENTER	1998 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT POVERTY LEVEL FAMILY OF THREE
Barrington	$801	$17,845	54%	$13,650	70%
Bristol	$571	$17,845	38%	$13,650	50%
Burrillville	$650	$17,845	44%	$13,650	57%
Central Falls	$493	$17,845	33%	$13,650	43%
Charlestown	$716	$17,845	48%	$13,650	63%
Coventry	NA	$17,845	NA	$13,650	NA
Cranston	$642	$17,845	43%	$13,650	56%
Cumberland	$600	$17,845	40%	$13,650	53%
East Greenwich	$843	$17,845	57%	$13,650	74%
East Providence	$651	$17,845	44%	$13,650	57%
Exeter	NA	$17,845	NA	$13,650	NA
Foster	NA	$17,845	NA	$13,650	NA
Glocester	NA	$17,845	NA	$13,650	NA
Hopkinton	NA	$17,845	NA	$13,650	NA
Jamestown	NA	$17,845	NA	$13,650	NA
Johnston	$592	$17,845	40%	$13,650	52%
Lincoln	$605	$17,845	41%	$13,650	53%
Little Compton	NA	$17,845	NA	$13,650	NA
Middletown	$618	$17,845	42%	$13,650	54%
Narragansett	$843	$17,845	57%	$13,650	74%
Newport	$760	$17,845	51%	$13,650	67%
New Shoreham	NA	$17,845	NA	$13,650	NA
North Kingstown	$659	$17,845	44%	$13,650	58%
North Providence	$624	$17,845	42%	$13,650	55%
North Smithfield	$675	$17,845	45%	$13,650	59%
Pawtucket	$551	$17,845	37%	$13,650	48%
Portsmouth	$846	$17,845	57%	$13,650	74%
Providence	$609	$17,845	41%	$13,650	54%
Richmond	$680	$17,845	46%	$13,650	60%
Scituate	NA	$17,845	NA	$13,650	NA
Smithfield	$756	$17,845	51%	$13,650	66%
South Kingstown	$660	$17,845	44%	$13,650	58%
Tiverton	$645	$17,845	43%	$13,650	57%
Warren	$539	$17,845	36%	$13,650	47%
Warwick	$672	$17,845	45%	$13,650	59%
Westerly	$669	$17,845	45%	$13,650	59%
West Greenwich	NA	$17,845	NA	$13,650	NA
West Warwick	$626	$17,845	42%	$13,650	55%
Woonsocket	$476	$17,845	32%	$13,650	42%
Core Cities	*$572*	*$17,845*	*38%*	*$13,650*	*50%*
Remainder of State	*$637*	*$17,845*	*43%*	*$13,650*	*56%*
Rhode Island	*$613*	*$17,845*	*41%*	*$13,650*	*54%*

Source of Data for Table/Methodology

Rhode Island Housing, January 1999. A low-income renter is defined as 30% below 1998 median renter income. Rent burdens over 30% are considered unaffordable. Average rents are based on a biannual survey of rents in Rhode Island during 1998. Rents include the HUD allowance for heat, if heat was not included in the advertised rent.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References for Indicator

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[2][3][4] Daskal, J. (June 15, 1998). *In Search of Shelter: The Growing Shortage of Affordable Rental Housing*. Washington, DC: Center on Budget and Policy Priorities.

[5][6] *America's Children: Key National Indicators of Well Being* (1997). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[7] *Children and Their Housing Needs: A Report to KIDS COUNT* (1994). Washington, DC: Center on Budget and Policy Priorities.

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[9] *Not Safe at Home: How America's Housing Crisis Threatens the Health of Its Children* (February 1998). Boston: The Dot4Kids Project, Boston Medical Center and Children's Hospital.

[10] Rhode Island Department of Human Services, INRHODES Database, December 1, 1998.

[11] U.S. Bureau of the Census, Current Population Survey, 1994-1998 average.

[12] Teresa and H. John Heinz III Foundation and MassINC (December 1998). "The Road Ahead: Emerging Threats to Workers, Families, and the Massachusetts Economy." Boston, MA: Massachusetts Institute for a New Commonwealth.

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Children in Poverty

DEFINITION

Children in poverty is the percentage of related children under age 18 who live in families below the poverty threshold, as defined by the U.S. Office of Management and Budget. "Related children" include the family head's children by birth, marriage, and adoption, as well as other persons under age 18 who are related to and live with the family head, such as nieces and nephews.

SIGNIFICANCE

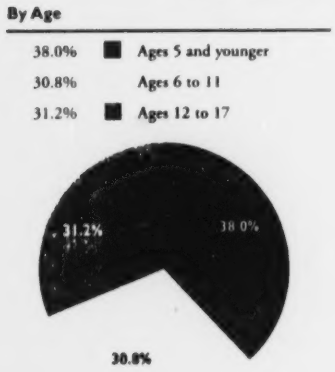
Children most at risk of not achieving their full potential are children in poverty, regardless of race.[1] Poverty is related to every KIDS COUNT indicator. Children who grow up in poor families are more likely to go without necessary food and clothing, lack basic health care, live in substandard housing, and have unequal access to educational opportunities.[2] Children in low-income communities are more likely to attend schools with outdated instructional materials and inadequate classroom facilities; have less access to libraries, museums, and cultural activities; have limited access to high quality child care programs; and have fewer opportunities to participate in sports, recreation, and enrichment programs after school and in the summer.[3,4]

Single parenthood, low educational attainment, part-time or no employment, and low wages place children at risk for being poor.[5] Family economic conditions in early and middle childhood appear to be more important for shaping ability and achievement than do economic conditions during adolescence.[6] Efforts that improve the quality of a child's environment, especially in the early years of life, can produce lifelong impacts on learning, social skills, and mental health.[7]

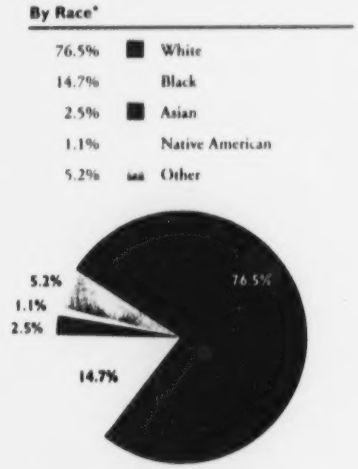
Over time, many more people are poor than the official poverty line suggests. There is considerable movement into and out of poverty each year.[8] Those living with incomes close to the poverty line are vulnerable to falling into poverty due to changes in employment, housing and utility costs, and life changes such as the birth of a child, changes in marital status, and illness or disability.[9] In 1998, the official poverty level for a family of four was $16,450. This is less than half the median family income for Rhode Island families with children.[10]

Rhode Island's Poor Children, 1996

By Age

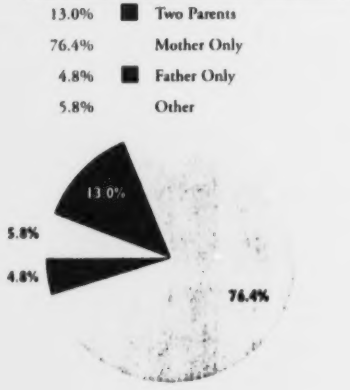


By Race*



**Hispanic children may be included in any race category. Of Rhode Island's 39,040 poor children, 28.5% are Hispanic.*

By Family Structure



◆ In 1996, there were 39,040 poor children in Rhode Island, 18% of all Rhode Island children. This is an increase from the 1990 Census figure when 14% of children lived in poverty.

◆ More than three-quarters of Rhode Island's poor children are white; yet, Black, Hispanic, and Native American children are three times more likely to be living in poverty.

Source: U.S. Bureau of the Census, Current Population Survey, 1994-1998 average.

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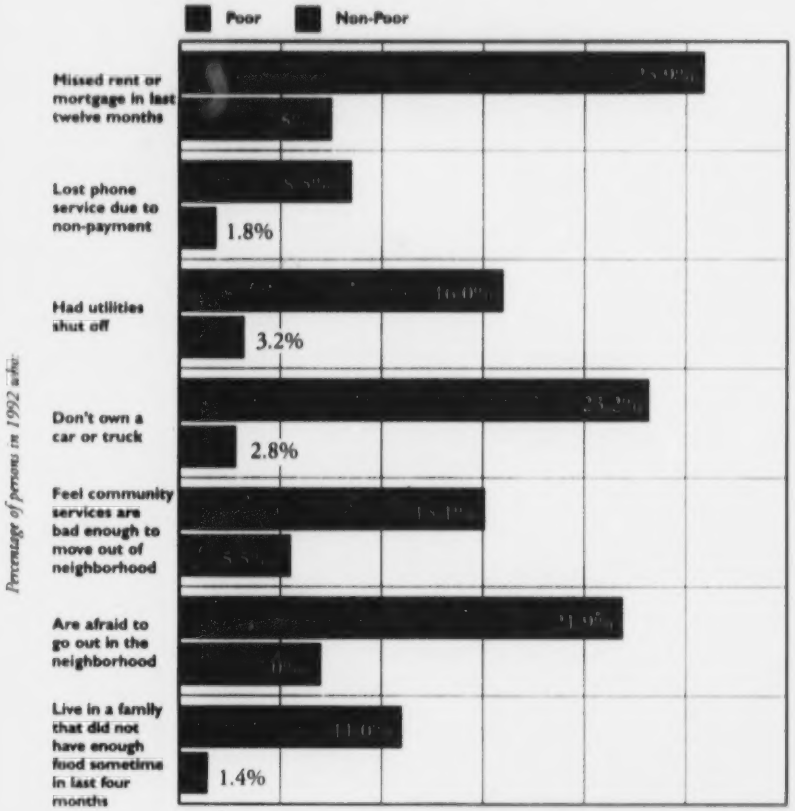
Living Conditions of Persons in Poor and Non-Poor Families


Poor
Non-Poor
Missed rent or mortgage in last twelve months
Lost phone service due to non-payment
1.8%
Had utilities shut off
3.2%
Don't own a car or truck
2.8%
Feel community services are bad enough to move out of neighborhood
Are afraid to go out in the neighborhood
Live in a family that did not have enough food sometime in last four months
1.4%
Percentage of persons in 1992 who:

Source: *CDF Reports* (July 1998). Volume 19, Number 7. Washington, DC: Children's Defense Fund, using national survey data compiled by Federman, M. et. al. (1996). "What does it mean to be poor in America?" *Monthly Labor Review*, 199, 3-17. "Poor" is defined as family income below the federal poverty level.

Young Children in Poverty, Rhode Island, 1996

◆ In 1996, 38% of Rhode Island's poor children were under age 6. One in five Rhode Island children under the age of six was living in poverty.[11]

◆ As of December 1, 1998, there were 14,554 young children under age 6 in families receiving cash assistance from the Rhode Island Family Independence Program (which replaced Aid to Families with Dependent Children).[12] Of all children in the Family Independence Program, 41% are under age 6.

◆ Research shows that the quality of a child's environment and social interactions in the early years affect brain development, producing lifelong impacts on learning, social skills, and mental health.[13]

◆ Young children born into poverty are more likely to...[14]

be born low birthweight;
die in infancy or early childhood;
be hospitalized during childhood;
receive lower quality medical care;
experience hunger and malnutrition;
be victims of or witnesses to violence;
be exposed to environmental toxins.

School-Age Children in Low-Income Families

◆ Between 1990 and 1998, the percentage of Rhode Island students ages 5 to 18 living in families with income below 185% of the federal poverty level has increased from 23% (31,719) of all students to 35% (50,466) of all students.[15]

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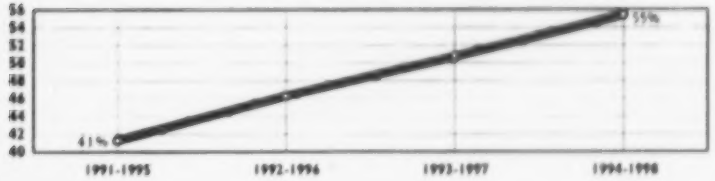
Children in Poverty

Percentage of Poor Families Working Full-time or Part-time, Rhode Island, 1991-1998



Source: U.S. Bureau of the Census, Current Population Survey, 5-year averages for 1991-1995, 1992-1996, 1993-1997, 1994-1998.

◆ Between 1994 and 1998, 55% of Rhode Island families with incomes below the poverty line worked full or part-time, up from 41% between 1991 and 1995.[16]

◆ Factors related to poverty among working families include the predominance of service and retail jobs that pay lower wages, the inability to find full-time year-round work, low educational attainment, and single parenthood.[17]

◆ In 1996, almost one-third of all Rhode Island children (32%) lived in families in which neither parent was employed full-time year-round. Without secure parental employment, children are at increased risk of poverty.[18]

◆ The Center on Budget and Policy Priorities special report on the working poor found that in the the mid-1990s, over 40% of poor Rhode Island families with children had earnings as the majority of their income and 46% of families receiving cash assistance had a parent who worked at least part of the year. Almost one in five (18%) working poor families had a full-time year-round worker.[19]

◆ The economic mobility of younger families in the U.S. has been constrained by the stagnant or declining family income growth since the late 1980s. In the past two decades, young families have started out at lower incomes and obtained slower income gains as they approach middle age.[20]

40

Building Blocks for Economic Self-Sufficiency

◆ Educational Attainment

Individuals with higher education generally have more job opportunities, higher wages, and greater job security that those with lower levels of education.[21] Each added level of educational attainment, beginning with a high school degree and continuing on through college to graduate or professional school, increases a family's median income.[22] A high school diploma, without a college degree, no longer ensures a path to economic security.[23]

◆ High Quality Child Care

In order to work, parents need access to high quality, affordable child care for their pre-school and school-age children. In Rhode Island, all families with incomes up to 200% of the federal poverty line are eligible for child care subsidies for children up to age 14. Part-time, temporary or seasonal work, and non-traditional work shifts make child care arrangements fragile.[24] The quality and stability of the child care setting is critical to parent's ability to work and to the child's development.

◆ Affordable Housing

In the Northeast, four out of five poor renters pay more than 30% of their income on housing, a level that is considered to be unaffordable. Nationally, a third of working families paid more than 30% of income for housing and lived in physically deficient, overcrowded, or "doubled-up" housing.[25]

◆ Tax Policies that Help Working Families

The federal EITC is a refundable credit on the federal income tax, available since 1975, to low-income and moderate-income working families with children. EITC increases the income available to working poor families and helps to bring low-wage earners up to the poverty threshold (when combined with Food Stamps).[26] The state of Rhode Island has a non-refundable EITC that can only be used to provide income tax relief; if the size of the EITC exceeds the tax bill, the Rhode Island tax credit is forfeited.

41

Table 5.

Child Poverty, Rhode Island, 1990

CITY/TOWN	FAMILIES WITH CHILDREN BELOW POVERTY		CHILDREN UNDER 18 BELOW POVERTY		CHILDREN UNDER 6 BELOW POVERTY	
	#	%	#	%	#	%
Barrington	27	1.3%	52	1.3%	33	2.6%
Bristol	108	4.5%	253	5.9%	128	8.3%
Burrillville	148	6.3%	276	6.1%	119	8.5%
Central Falls	710	28.5%	1,576	32.5%	749	38.0%
Charlestown	68	7.8%	145	9.4%	39	6.4%
Coventry	199	4.7%	402	5.3%	180	7.3%
Cranston	735	8.9%	1,378	9.5%	562	10.9%
Cumberland	145	4.0%	302	4.7%	151	7.4%
East Greenwich	75	4.6%	153	5.3%	112	13.0%
East Providence	499	8.0%	904	8.7%	355	9.9%
Exeter	26	3.3%	52	3.6%	5	1.0%
Foster	34	5.5%	88	7.6%	0	0.0%
Glocester	99	7.2%	156	6.5%	77	10.0%
Hopkinton	40	4.1%	75	4.1%	9	1.4%
Jamestown	59	8.9%	92	8.1%	45	11.9%
Johnston	266	9.0%	452	8.4%	187	10.6%
Lincoln	164	7.2%	272	7.0%	98	7.2%
Little Compton	12	2.6%	20	2.7%	15	5.1%
Middletown	129	5.1%	275	6.0%	158	9.1%
Narragansett	71	4.4%	122	4.5%	36	3.6%
Newport	559	17.7%	1,143	20.3%	575	27.0%
New Shoreham	12	12.4%	17	10.1%	6	10.0%
North Kingstown	185	5.4%	281	4.7%	121	6.1%
North Providence	182	5.6%	298	5.4%	78	4.3%
North Smithfield	23	1.7%	37	1.6%	19	3.1%
Pawtucket	1,255	13.4%	2,525	15.5%	1,096	17.3%
Portsmouth	95	3.8%	182	4.4%	70	5.2%
Providence	5,621	29.2%	12,946	34.5%	5,531	36.8%
Richmond	9	1.1%	30	2.0%	0	0.0%
Scituate	45	3.3%	91	3.7%	19	2.3%
Smithfield	75	3.4%	155	4.1%	61	4.9%
South Kingstown	134	4.9%	350	7.5%	133	8.7%
Tiverton	109	6.0%	200	6.4%	81	7.9%
Warren	132	9.3%	199	8.5%	56	6.2%
Warwick	519	5.1%	1,084	5.9%	448	7.2%
Westerly	210	7.3%	432	8.7%	224	12.9%
West Greenwich	14	2.9%	26	2.9%	11	4.2%
West Warwick	395	10.7%	746	11.8%	291	13.0%
Woonsocket	1,183	20.0%	2,235	21.4%	1,034	26.9%
Core Cities	***9,328***	***23.2%***	***20,425***	***27.3%***	***8,985***	***30.7%***
Remainder of State	***5,043***	***6.0%***	***9,597***	***6.5%***	***3,927***	***7.9%***
Rhode Island	***14,371***	***11.6%***	***30,022***	***13.5%***	***12,912***	***16.3%***

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 *Census of Population*. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is all children under age 18 according to the 1990 Census of Population.

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Children in the Family Independence Program

DEFINITION

Children enrolled in the Family Independence Program is the percentage of children less than age 18 who were living in families receiving cash assistance through the Family Independence Program (FIP) on December 1, 1998. These data measure the number of children and families enrolled in FIP at one point in time. They do not count the additional children and families who qualified for the program at other points in the year but were not enrolled on December 1, 1998.

SIGNIFICANCE

Rhode Island's Family Independence Program seeks to help families make successful transitions to work by providing the supports, including health insurance and subsidized child care, that families need to obtain and keep a job. The Family Independence Program allows two-parent and single-parent families to obtain cash assistance. The program improves work incentives by allowing working recipients to keep more of their earnings before cash assistance is decreased or terminated.

Through FIP, children in families that are income-eligible are entitled to cash assistance without time limits. A five-year time limit for cash benefits is placed on adults in the family. If a family has no earned income, the maximum monthly FIP benefit for a Rhode Island family of three is $554 per month.[1] With an additional $329 per month in Food Stamps, the monthly combined benefit is $883. This amount is 78% of the federal poverty level. While cash benefits alone do not lift families out of poverty, they provide a minimal subsistence for poor families. When combined with earned income and the earned income tax credit, cash assistance can move a family working full-time at minimum wage above the poverty line of $13,650 for a family of three. As of December 31, 1998 in Rhode Island, 27% of the 16,035 adults receiving FIP cash assistance were employed.[2]

As of December 1, 1998, there were 35,109 Rhode Island children receiving cash assistance through the Family Independence Program. In the core cities as a whole (Providence, Pawtucket, Central Falls, Woonsocket and Newport), 29% of children receive cash assistance through FIP compared to 6% of children in the remainder of the state. More than 80% of all children receiving cash assistance through FIP are ages 12 and under.[3]

Elements of Effective Welfare Reform

Assists families in obtaining sustainable jobs that move them out of poverty and into economic self-sufficiency.

◆ Low-income working families require adequate income to meet their needs for housing, food, clothing, health insurance, child care, and transportation. Entry into sustainable jobs at a sufficient wage requires assistance with job placement, job training, English-language programs, literacy programs, vocational education, and post-secondary education.[4]

Supports the healthy development of children.

◆ Welfare reforms that increase family income, improve access to health care for children and families, and ensure that children have access to affordable, high-quality child care are likely to have positive impacts on child well-being.[5,6]

◆ In Rhode Island, full or partial child care subsidies are available for FIP recipients and for low-income working families up to 200% of poverty; increasing to 225% of poverty on July 1, 1999 and to 250% of poverty on July 1, 2000. Health insurance through RIte Care, Rhode Island's Medicaid managed care program, is available to all FIP recipients, to parents in families with incomes up to 185% of poverty, and to all children under age 18 up to 250% of poverty.

Provides access to a range of supports needed by low-income families.

◆ It is the combination of benefits and support systems that is most likely to lift families out of poverty and enhance the well-being of children.[7] Families need information and help in accessing the variety of benefit programs that are available to them, including cash assistance through the Family Independence Program, food assistance (Food Stamps, WIC, School Lunch and School Breakfast), RIte Care health insurance, subsidized child care, Earned Income Tax Credit, and child support collection.[8]

◆ Some families will need a variety of social supports and social services in order to successfully transition from welfare to work, including assistance with housing needs, transportation, substance abuse, domestic violence, or other issues.[9]

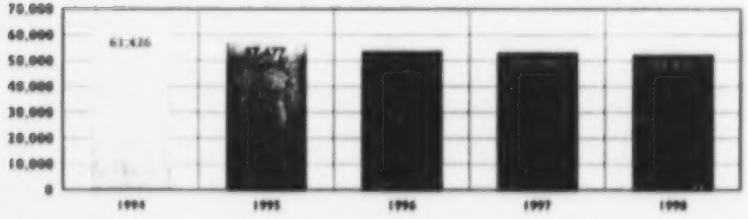
Children in the Family Independence Program

The Rhode Island Family Independence Program

Under the federal welfare reform law that replaced AFDC with the Temporary Assistance for Needy Families program (TANF), states are allowed to develop their own support programs for needy families. The Family Independence Program is Rhode Island's welfare reform program as set forth in the Rhode Island Family Independence Act of 1996.

- One and two parent families are eligible for cash assistance if their income is less than 100% of the poverty line.
- Unless exempt from the work requirements, adult recipients must develop an employment plan with a FIP social worker. As of December 1998, 56% of the 12,482 adult recipients who need employment plans have one. The employment plan identifies the training, education, work readiness, or work in which the recipient will participate.
- Eligible teen parents under age 18 must live at home or in a supervised setting and stay in school.
- Working cash recipients can earn up to $170 monthly without a reduction in cash assistance amount. After the first $170, benefits are reduced $1 for $2 earned.
- There is a five-year time limit on receipt of cash assistance by adults unless they receive an exemption; cash assistance to eligible children is without time limits.

Adults and Children Enrolled in AFDC/Family Independence Program, 1994 to 1998



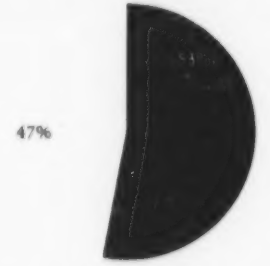
Source: Rhode Island Department of Human Services, INRHODES Database, 1994 to 1998.
Note: Prior to May 1, 1997, the Family Independence Program was AFDC (Aid to Families with Dependent Children).

Families Enrolled in the Family Independence Program, December 1998

By Family Type

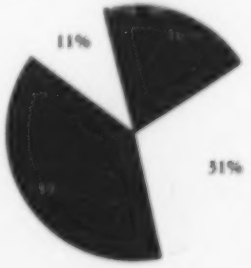
n = 18,509

By Participation in Work/ Education/Training



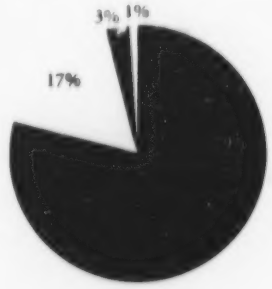
n = 12,482
(Includes all adults with work, work preparation, education requirements.)

By Education Level of Household Head



n = 16,035
(Does not include the 2,474 child only families.)

By Primary Language



n = 18,509

Source: Rhode Island Department of Human Services, InRHODES Database, December 1998.

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Children in the Family Independence Program

Measuring Economic Self-Sufficiency: Weaknesses of the Current Federal Poverty Level

The National Academy of Sciences, after completing a comprehensive assessment of the federal poverty guidelines, highlighted six weaknesses of the current federal poverty standard:

- It does not allow for costs of employment, particularly child care costs.
- It does not allow for the costs of health care.
- There is no adjustment for geographical differences in living costs, especially housing.
- The standard lacks a mechanism by which it can be updated to reflect revised understanding of what is a "necessity" - for example, telephones.
- The increments for increasing family size are neither uniform nor regular.
- There is no allowance for the impact of taxes on family income and no allowance for the impact of near-cash benefits, such as food stamps, on the real level of family resources.

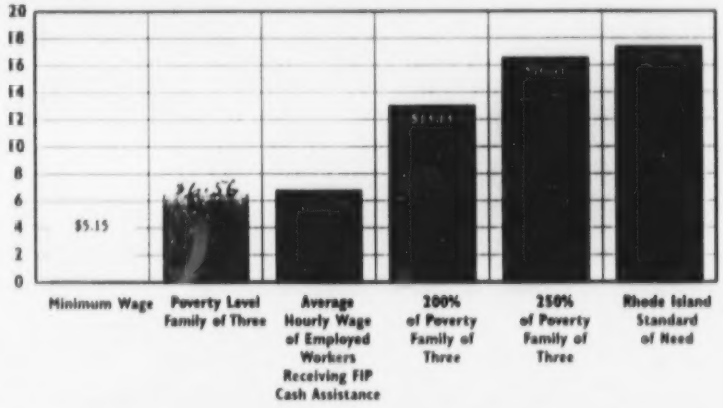
Source: Diana M. Pearce (1998). *Six Strategies for Self Sufficiency.* Washington, DC: Wider Opportunities for Women; and National Research Council (1995). *Measuring Poverty: A New Approach.* Washington, DC: National Academy Press.

Family Income Levels Based on the Federal Poverty Line

Many government assistance programs for low-income people now use 185% of the federal poverty line (rather than 100% of the poverty line) as the eligibility cut-off. Rhode Island health insurance and child care subsidy programs use 200% to 250% of the federal poverty line as the upper limits for income eligibility. These figures are adjusted upward for larger for family sizes. The income levels reflected here are for a family of three.

Federal Poverty Level (FPL)	Annual Income Family of Three	Hourly Wage Full-Time, Full-Year
100% FPL	$13,650	$6.56
130% FPL	$17,745	$8.53
185% FPL	$25,253	$12.14
200% FPL	$27,300	$13.13
250% FPL	$34,125	$16.41

Wages Compared to the Standard of Need, Rhode Island, 1999



- For a single parent in Providence with one pre-school child and one school-age child, the hourly wage needed for self-sufficiency is $17.50 (termed the "standard of need"). In general, families whose income is below the "standard of need" lack the ability to secure their basic needs for food, shelter, health care, and child care at a minimally adequate level unless they have access to subsidies.

- Child care subsidies, because they substantially reduce the cost of what is the single most expensive need for many families, are a critical resource to families with incomes up to 250% of the federal poverty line.

- Public housing, food stamps, RIte Care, the FIP Earned Income Disregard, child care subsidies, and the Earned Income Tax Credit are important policies to ensure that low-income working families have adequate resources to meet their basic needs (including health care, child care, housing, and transportation).

Source: Poverty Institute at Rhode Island College (1999), using methodology for the Self-Sufficiency Standard developed by Diana M. Pearce, Ph.D., Swarthmore College and Wider Opportunities for Women, Inc.; and Diana M. Pearce, Ph.D. (March 1998). *When Wages Aren't Enough.* Philadelphia, PA: Pennsylvania Family Economic Self-Sufficiency Project and the Women's Association for Women's Alternatives, Inc.

48 BEST COPY AVAILABLE 49

Table 6.

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1, 1998

CITY/TOWN	ESTIMATED 1998 CHILDREN UNDER 18	NUMBER RECEIVING FIP CASH ASSISTANCE: FAMILIES	NUMBER RECEIVING FIP CASH ASSISTANCE: CHILDREN	FIP CHILDREN AS % OF ALL CHILDREN UNDER 18
Barrington	3,582	27	44	1.2%
Bristol	4,520	138	229	5.1%
Burrillville	4,039	93	182	4.5%
Central Falls	5,681	911	1,795	31.6%
Charlestown	1,707	43	74	4.3%
Coventry	7,317	204	317	4.3%
Cranston	15,361	963	1,593	10.4%
Cumberland	6,362	145	245	3.9%
East Greenwich	2,535	55	88	3.5%
East Providence	10,630	593	989	9.3%
Exeter	1,481	23	37	2.5%
Foster	1,091	19	27	2.5%
Glocester	2,239	43	68	3.0%
Hopkinton	1,855	53	83	4.5%
Jamestown	1,066	15	19	1.8%
Johnston	5,658	332	545	9.6%
Lincoln	3,854	129	224	5.8%
Little Compton	680	9	12	1.8%
Middletown	4,920	100	166	3.4%
Narragansett	2,949	99	166	5.6%
Newport	6,285	540	1,057	16.8%
New Shoreham	213	4	6	2.8%
North Kingstown	5,847	230	369	6.3%
North Providence	6,005	390	657	10.9%
North Smithfield	1,961	26	38	1.9%
Pawtucket	18,480	2,032	3,744	20.3%
Portsmouth	3,922	55	90	2.3%
Providence	45,240	7,786	16,231	35.9%
Richmond	1,638	42	74	4.5%
Scituate	2,218	40	62	2.8%
Smithfield	3,692	60	89	2.4%
South Kingstown	4,871	120	222	4.6%
Tiverton	2,781	73	112	4.0%
Warren	2,511	109	205	8.2%
Warwick	18,177	781	1,245	6.8%
Westerly	5,383	254	460	8.5%
West Greenwich	978	22	38	3.9%
West Warwick	7,194	488	806	11.2%
Woonsocket	11,350	1,388	2,701	23.8%
Core Cities	*87,016*	*12,657*	*25,528*	*29.3%*
Remainder of State	*149,219*	*5,777*	*9,581*	*6.4%*
Rhode Island	*236,234*	*18,434*	*35,109*	*14.9%*

Source of Data for Tables/Methodology

Rhode Island Department of Human Services, INRHODES Database, December 1, 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the number of children ages one to ten according to the 1990 Census of Population, plus seven times the average number of births for the years 1991 to 1997, minus the average number of deaths for the same years.

References for Indicator

[1] [2] Rhode Island Department of Human Services, INRHODES Database, December 1, 1998.

[2] Rhode Island Department of Human Services, December 31, 1998.

[3] *Welfare That Works: The Working Lives of AFDC Recipients, A Report to the Ford Foundation* (1995). Washington: Institute for Women's Policy Research.

[4] Collins, A., Jones, S., Bloom, H. (1996). *Children and Welfare Reform: Highlights from Recent Research.* New York: National Center for Children in Poverty, Columbia University School of Public Health.

[5] Bogenschneider, K. and T. Corbett. *Welfare Reform: Can Government Promote Parental Self-Sufficiency While Ensuring the Well-Being of Children?* (1995). Madison, WI: University of Wisconsin-Madison Institute for Research on Poverty.

[6] [7] *The Safety Net Delivers: The Effects of Government Benefits Programs in Reducing Poverty* (1996). Washington, DC: Center on Budget and Policy Priorities.

[8] *Meeting the Challenges of Welfare Reform: Programs with Promise* (1998). Denver, CO: National Conference of State Legislatures.

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Children Receiving Food Stamps

DEFINITION

Children receiving food stamps is the percentage of income-eligible children under age 18 who participate in the Food Stamp program.

SIGNIFICANCE

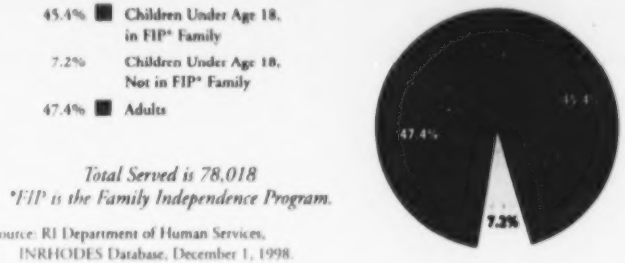
The Food Stamp program provides monthly benefits which can be used for the purchase of food at retail stores. Research shows that participation in the Food Stamp program increases a family's ability to purchase an adequate low-cost diet and helps low-income households achieve better nutritional intake.[1,2] The Food Stamp program provides important nutrition benefits to low-income families who would otherwise be at high risk for undernutrition and poor health.[3]

To qualify for Food Stamps, a household's gross income must be less than 130% of the poverty level for that family size and meet requirements which limit the value of assets (such as cash and automobiles). For example, a family of four with an annual income less than $21,385 (monthly income less than $1,782) will qualify for Food Stamps if they meet the assets guidelines.

The Food Stamp program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. One of the strengths of the Food Stamp program is its ability to respond to changes in the state's economy.[4] The benefit level for each eligible household is adjusted according to income. The monthly benefit level decreases as household income increases.

The maximum monthly Food Stamp benefit for a family of three is $329. The average monthly benefit for family of three in Rhode Island is $203, a decrease from the 1997 monthly average of $270.[5] There were 41,056 children in Rhode Island who received benefits from the Food Stamp program, as of December 1, 1998. More than half of all food stamp recipients in Rhode Island are children under age 18.[6] Nationally, households with children receive 80% of all food stamp benefits.[7]

Food Stamp Participation by Age, Rhode Island, December 1998



Total Served is 78,018
**FIP is the Family Independence Program.*

Source: RI Department of Human Services, INRHODES Database, December 1, 1998.

Outreach to Families Eligible for Food Stamps

◆ A family does not need to be eligible for, or receiving assistance through, the Family Independence Program (FIP) to qualify for food stamps. The federal welfare law requires that states develop adequate procedures to ensure that families that are denied, diverted from, or terminated from the Family Independence Program are fully considered for food stamp benefits for which they qualify.[8]

◆ Most families enrolled in FIP whose earnings cause them to become ineligible for cash assistance continue to have earnings sufficiently low that they still qualify for food stamp benefits.[9]

◆ Many of Rhode Island's legal immigrants qualify for food stamp benefits if they meet the income and assets guidelines. Rhode Island is one of 17 states that has state-funded food stamps for some legal immigrants who are no longer eligible for federally-funded food stamps.[10]

◆ Food stamp outreach programs can counteract barriers to enrollment by ensuring there is a flow of accurate information into communities; by training state and local human service providers on program regulations; and by providing application assistance to eligible households in need of food stamps.[11]

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Table 7. **Children Under 18 Receiving Food Stamps, Rhode Island, December 1, 1998**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER OF ELIGIBLE PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	50	43	85%
Bristol	NA	311	NA
Burrillville	553	253	46%
Central Falls	4,975	2,249	45%
Charlestown	NA	109	NA
Coventry	812	366	45%
Cranston	2,633	1,808	69%
Cumberland	678	324	48%
East Greenwich	131	100	76%
East Providence	2,644	1,184	45%
Exeter	NA	40	NA
Foster	142	30	21%
Glocester	300	93	31%
Hopkinton	NA	109	NA
Jamestown	59	20	34%
Johnston	819	644	79%
Lincoln	378	291	77%
Little Compton	64	32	50%
Middletown	681	226	33%
Narragansett	320	162	51%
Newport	2,543	1,292	51%
New Shoreham	4	5	100%
North Kingstown	584	384	66%
North Providence	1,125	723	64%
North Smithfield	135	61	45%
Pawtucket	9,387	4,491	48%
Portsmouth	183	116	63%
Providence	33,268	18,614	56%
Richmond	NA	92	NA
Scituate	148	67	45%
Smithfield	183	125	68%
South Kingstown	435	227	52%
Tiverton	337	107	32%
Warren	NA	257	NA
Warwick	2,453	1,447	59%
Westerly	753	584	78%
West Greenwich	NA	44	NA
West Warwick	2,099	916	44%
Woonsocket	5,436	3,110	57%
Core Cities	*56,358*	*29,756*	*53%*
Remainder of State	*19,774*	*11,300*	*57%*
Rhode Island	*74,726*	*41,056*	*55%*

Source of Data for Table/Methodology

Estimated number eligible is based on the total number of children ages birth to 18 (projections from the 1990 Census) multiplied by the % of students eligible for free School Lunch in each community. Families with incomes less than 130% of poverty are income-eligible for free School Lunch and for Food Stamps (the Food Stamp program also has an assets limitation as part of eligibility determination). Free lunch percentages are from the Rhode Island Department of Education, October 1998.

NA: Numbers are not available as community has a regional school district.

Food Stamp program participation data are from the Rhode Island Department of Human Services, INRHODES Database, December 1, 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References for Indicator

[1] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[2] Devaney, B.L., and M.R. Ellwood, J.M. Love. "Programs that Mitigate the Effects of Poverty on Children" in *The Future of Children: Children and Poverty*, Vol. 7, No. 2 (Summer/Fall 1997). Los Altos, CA: The David and Lucille Packard Foundation.

[3] Cook, J.T. (May 1998). "The Importance of the Food Stamp Program for Low-Income Legal Immigrants." Medford, MA: Tufts University Center on Hunger and Poverty.

[4] Rhode Island Department of Human Services, INRHODES Database, December 1, 1994 to 1998. Calculations by Rhode Island KIDS COUNT.

[5] "Federal Food Programs: Food Stamp Program" (December 1998). Washington, DC: Food Research and Action Center.

[6] Schott, L. "Assuring that Families Receive Food Stamp and Medicaid Benefits for Which They Qualify When TANF Assistance is Denied or Terminated" (August 27, 1998). Washington, DC: Center on Budget and Policy Priorities.

[7] "New Federal Food Stamp Restoration for Legal Immigrants" (July 10,1998). Washington, DC: Center on Budget and Policy Priorities.

[8] "Food Stamp Outreach: A Survey of State Activities" (December 1998). Washington, DC: Food Research and Action Center.

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Children Receiving School Breakfast

DEFINITION

Children receiving school breakfast is the percentage of low-income public school children who attend schools offering the School Breakfast Program. Half-day kindergarten, private schools, and residential child care facilities are not included in the calculations. Children are counted as low-income if they are eligible for and enrolled in free or reduced price lunch.

SIGNIFICANCE

Undernutrition during any period of childhood can have a detrimental impact on a child's cognitive development. The longer a child's nutritional needs go unmet, the greater the risk of cognitive impairment.[1] Low-income students are more likely than other students to arrive at school without an adequate breakfast.[2] The School Breakfast Program offers nutritious meals to children at participating schools, providing children with one-fourth or more of their Recommended Daily Allowance for key nutrients.[3]

Federal and state funds are available to support the costs of the School Breakfast Program. 157 of the 315 public schools in Rhode Island offer the School Breakfast Program. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Family Independence Program households are automatically eligible for free meals.

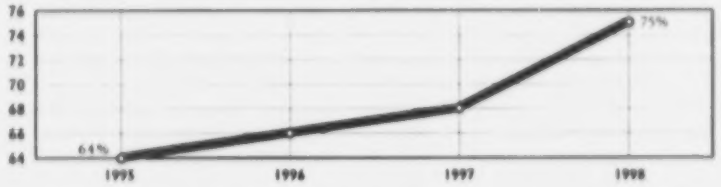
Children who participate in the School Breakfast Program have better school attendance, are more likely to arrive at school on time, and have higher standardized test scores than non-participants.[4]

Percentage of Low-Income Children Attending Schools Offering School Breakfast, Selected School Districts, 1995 and 1998

	1995	1998
Burrillville	100%	100%
Central Falls	100%	100%
Providence	100%	100%
West Warwick	29%	100%
Westerly	89%	91%
Cumberland	66%	86%
Woonsocket	86%	85%
Bristol Warren	31%	70%
Cranston	47%	70%
East Greenwich	66%	65%
Newport	17%	59%
Pawtucket	21%	58%
East Providence	66%	56%
Core Cities	81%	90%
Rhode Island	64%	75%

Source: Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, 1995 and 1998. Calculations by Rhode Island KIDS COUNT.

Percentage of Low-Income Children Attending Schools Offering the School Breakfast Program, Rhode Island, 1995 to 1998



- The percentage of students attending schools offering the School Breakfast Program has increased from 64% in the Fall of 1995 to 75% in the Fall of 1998. In 1998, there were 157 public schools offering the School Breakfast Program, up from 116 schools in 1995.

- There are 12,639 low-income public school students who are not receiving school breakfast because they attend the 158 Rhode Island public schools that do not participate in the School Breakfast Program.

Source: Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, 1995-1998. Calculations by Rhode Island KIDS COUNT.

Increased Access to School Breakfast, Rhode Island, 1995 to 1998

- The 1998 Rhode Island General Assembly passed a mandatory school breakfast law requiring that all public elementary schools in which 40% or more of the students are eligible for free or reduced priced lunches offer the School Breakfast Program. Twenty-three states have laws mandating the provision of the School Breakfast Program.[5]

- Rhode Island's School Breakfast mandate required 15 additional elementary schools, primarily in Newport and Pawtucket, to offer the program. In addition, the law insures that the 66 schools with over 40% of the students in free or reduced priced lunch that are already offering the breakfast program continue to do so.

- In Rhode Island, increasing the mandate to require School Breakfast for all schools in which 20% or more of the students are low-income would affect 188 schools in 24 school districts. 139 of the 188 schools were already offering the School Breakfast Program in 1998.[6]

Table 8. **Low-Income Children with Access to School Breakfast, Rhode Island, Fall 1998**

SCHOOL DISTRICT	NUMBER OF LOW-INCOME STUDENTS IN DISTRICT	NUMBER OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST	PERCENT OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST	TOTAL NUMBER OF SCHOOLS IN DISTRICT	NUMBER OF SCHOOLS >10% FREE/REDUCED PRICE LUNCH	NUMBER OF SCHOOLS >40% FREE/REDUCED PRICE LUNCH
Barrington	73	0	0%	6	0	0
Bristol-Warren	1,044	730	70%	11	8	3
Burrillville	573	573	100%	5	4	0
Central Falls	3,145	3,145	100%	8	8	8
Chariho	476	152	32%	6	1	0
Coventry	871	297	34%	9	3	0
Cranston	2,129	1,500	70%	23	12	5
Cumberland	585	501	86%	8	3	0
East Greenwich	127	82	65%	6	0	0
East Providence	2,010	1,143	56%	15	12	7
Exeter-W. Greenwich	236	102	43%	4	0	0
Foster	60	0	0%	1	0	0
Foster-Glocester	120	0	0%	2	0	0
Glocester	134	0	0%	2	0	0
Jamestown	46	0	0%	2	0	0
Johnston	552	206	37%	8	4	0
Lincoln	356	34	10%	7	1	0
Little Compton	37	0	0%	1	0	0
Middletown	568	0	0%	6	4	0
Narragansett	253	0	0%	3	0	0
Newport	1,347	800	59%	9	9	7
New Shoreham	8	0	0%	1	0	0
North Kingstown	551	0	0%	10	3	0
North Providence	717	312	44%	9	7	0
North Smithfield	170	0	0%	4	0	0
Pawtucket	5,612	3,249	58%	16	16	14
Portsmouth	180	3	2%	6	1	0
Providence	19,827	19,827	100%	49	49	48
Scituate	150	0	0%	5	0	0
Smithfield	169	66	39%	6	1	0
South Kingstown	465	0	0%	8	2	1
Tiverton	400	0	0%	6	3	0
Warwick	2,091	315	15%	26	11	1
Westerly	616	563	91%	7	5	0
West Warwick	1,183	1,183	100%	6	5	3
Woonsocket	3,565	3,044	85%	14	14	12
Core Cities	*33,496*	*30,065*	*90%*	*93*	*92*	*81*
Remainder of State	*16,970*	*7,762*	*46%*	*222*	*96*	*28*
Rhode Island	*50,466*	*37,827*	*75%*	*315*	*188*	*109*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Number of low-income students is the number of students eligible for and enrolled in free or reduced price lunches in the Fall of 1998. Low-income students receiving breakfast is the percent of students enrolled in free or reduced priced lunches who attend schools serving breakfast in the Fall of 1998. Half-day kindergarten, private schools and residential child care facilities may offer the School Breakfast Program, but are not included in these calculations.

The denominator is the number of children enrolled in the public school who are eligible for and enrolled in free or reduced price lunches in the Fall of 1998, not including half-day kindergarten.

References for Indicator

[aaa] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[bb] *School Breakfast Scorecard 1998: FRAC's Annual Status Report on the School Breakfast Program* (1998). Washington, DC: Food Research and Action Center.

[c] Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 1998. Calculations by Rhode Island KIDS COUNT.

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Health

60

February Twilight

I stood beside a hill
Smooth with new-laid snow,
A single star looked out
From the cold evening glow.

There was no other creature
That saw what I could see—
I stood and watched the evening star
As long as it watched me.

— Sara Teasdale

62

63

Children's Health Insurance

DEFINITION

Children's health insurance is the percentage of children under age 18 who were covered by any kind of public or private health insurance, including Medicaid, during the previous calendar year. These data reflect only those who were insured through the entire year and do not include those who were insured for only part of the year.

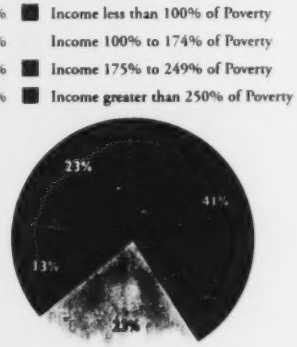
SIGNIFICANCE

Health care is vital to every child's healthy growth and development. Lack of insurance coverage makes it difficult to obtain primary and specialty care – including preventive health care, comprehensive treatment for acute and chronic illness, mental health services, dental care, and prescriptions.[1] Undiagnosed and untreated medical conditions can result in long-term health problems and interfere with learning and development.[2]

Insured children are more likely to have a relationship with a primary care physician, to receive required preventative services, and to receive a physician's care for health problems, such as asthma or ear infections.[3] Regular medical visits are especially critical during early childhood to receive immunizations and to be screened and treated for any developmental problems.[4]

Ten percent (22,000) of Rhode Island children are uninsured. Low family income and educational levels, lack of transportation, and language differences are barriers to obtaining health insurance and accessing health care services.[5] Many families do not enroll in public health insurance programs unless they are also applying for cash assistance.[6] Efforts that ensure continuity of insurance coverage for families as they change jobs and/or transition from cash assistance programs are critical to reducing the rates of uninsured children.[7]

Children Under Age 18 without Health Insurance, by Poverty Level, Rhode Island, 1996


41% Income less than 100% of Poverty
23% Income 100% to 174% of Poverty
13% Income 175% to 249% of Poverty
23% Income greater than 250% of Poverty
23%
41%
13%

n = 22,000

Source: U.S. Bureau of the Census, Current Population Survey, 1994-1998 average. Compiled by The Annie E. Casey Foundation.

RIte Care Health Insurance for Families

◆ RIte Care, Rhode Island's Medicaid managed care program, is available to the following groups:

Children under age 18 in families with income up to 250% of poverty.
Parents of eligible children, in families with income up to 185% of poverty.
Pregnant women up to 350% of poverty.
Families enrolled in the Family Independence Program.
Child care providers who serve low-income children.

◆ 69% of the 73,186 RIte Care clients enrolled on December 1, 1998 were children under age 18. Of the 50,356 children enrolled, 34% were enrolled in Neighborhood Health Plan of Rhode Island; 50% were enrolled in United Health Plans of New England; 9% were enrolled in Harvard/Pilgrim Health Care; and 7% in BlueCHIP.[8]

◆ More than three-quarters (77%) of the uninsured children in Rhode Island live in families under 250% of the federal poverty level and are therefore eligible to enroll in RIte Care.[9] Almost half (41%) of Rhode Island uninsured children live in families with incomes below the federal poverty line of $13,650 for a family of three.[10] Nationally, poor children and Hispanic children are the most likely to be uninsured.[11]

Health Care for Rhode Island Children with Disabilities

◆ As of December 1, 1998, there were 3,022 disabled Rhode Island children under age 18 receiving Supplemental Security Income (SSI).[12] SSI is a federal program that provides eligible children with disabilities up to $564 per month in cash assistance and enrolls them in Medicaid. The assistance helps families pay for food, clothing, shelter, and the extra costs of caring for a child with a disability.[13]

◆ From July 1, 1996 to June 30, 1997, there were 4,314 Rhode Island children and adolescents with disabilities enrolled in fee-for-service Medical Assistance. According to a 1998 Rhode Island survey, caregivers of these children reported the following as the top ten unmet needs: over-the-counter drugs (40%); support groups for parents (36%); information on the child's primary condition (35%); respite care (32%); transportation (29%); dental care (27%); day care and after-school care (24%); mental health counseling for the child (24%); parent education classes (22%); and case management (21%).[14]

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Table 9.

Children Under 18 Years Receiving Medical Assistance, Rhode Island, December 1998

CITY/TOWN	Rite Care FIP	Rite Care Non-FIP	SSI	Other	Total
Barrington	51	47	3	22	123
Bristol	243	138	12	14	407
Burrillville	209	178	12	13	412
Central Falls	1,920	760	101	5	2,786
Charlestown	85	67	5	3	160
Coventry	346	391	25	33	795
Cranston	1,673	865	82	74	2,694
East Greenwich	92	71	4	17	184
East Providence	1,088	567	52	43	1,750
Cumberland	279	184	15	27	505
Exeter	40	44	2	7	93
Foster	32	30	0	6	68
Glocester	85	76	7	6	174
Hopkinton	82	85	4	4	175
Jamestown	19	23	2	1	45
Johnston	588	342	25	18	973
Lincoln	259	154	17	15	445
Little Compton	14	25	2	1	42
Middletown	174	159	13	18	364
Narragansett	181	119	6	11	317
Newport	1,139	481	53	12	1,685
New Shoreham	9	6	0	0	15
North Kingstown	425	231	19	27	702
North Providence	697	311	30	16	1,054
North Smithfield	55	45	7	10	117
Pawtucket	4,014	1,638	245	50	5,947
Portsmouth	93	135	8	20	256
Providence	16,884	4,426	914	3,749	25,973
Richmond	74	69	11	18	172
Scituate	71	65	4	10	150
Smithfield	104	98	8	12	222
South Kingstown	262	233	18	21	534
Tiverton	97	199	8	4	308
Warren	223	166	10	5	404
Warwick	1,356	728	71	76	2,231
West Greenwich	39	33	5	5	82
West Warwick	896	413	36	26	1,371
Westerly	485	231	17	21	754
Woonsocket	2,820	654	172	30	3,676
Out of State	*70*	*10*	*51*	*0*	*131*
Unknown	*128*	*42*	*997*	*40*	*1,207*
Core Cities	*26,777*	*7,959*	*1,485*	*3,846*	*40,067*
Remainder of State	*10,554*	*6,570*	*1,537*	*644*	*19,305*
Rhode Island	*37,331*	*14,529*	*3,022*	*4,490*	*59,372*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, Center for Child and Family Health, INRHODES Database, December 1, 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The column labelled "Rite Care/FIP" is the number of children enrolled in Rite Care as of December 1, 1998 who also participate in the Family Independence Program. "Rite Care, Non-FIP" includes all other Rite Care participants under the age of 18 and pregnant women. "SSI" is children enrolled in fee-for-service Medicaid because they receive SSI. "Other" includes foster children and non-SSI children with disabilities who are enrolled in fee-for-service Medicaid. The Providence numbers for "other" include foster children who may live in other towns, because the DHS database lists foster children as Providence residents for administrative purposes.

References for Indicator

[1] "Health Insurance Coverage" in *The Future of Children*, Vol. 5, No. 3 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[2] *Caring Prescriptions: Comprehensive Health Care Strategies for Children in Poverty* (1993). New York: Columbia University, National Center for Children in Poverty.

[3] *Health Insurance Coverage Leads to Increased Health Care Access for Children* (1997). Washington DC, Government Accounting Office.

[4] *Unmet Needs: The Large Differences in Health Care Between Insured and Uninsured Children.* (1997). Washington, DC: Families USA.

[5] McManus, M. et.al. (1996). *Strengthening Partnerships between State Programs for Children with Special Health Needs and Managed Care Organizations.* Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

[6] Carpenter, M.B. and L. Kavanagh (1998). *Outreach to Children: Moving from Enrollment to Ensuring Access.* Rockville, MD: U.S. Department of Health and Human Services, Maternal and Child Health Bureau.

[7] Rhode Island Department of Human Services, Center for Child and Family Health, INRHODES Database, December 1, 1998.

[8] U.S. Bureau of the Census, Current Population Survey, 1994-1998 average. Compiled by The Annie E. Casey Foundation.

[9] *U.S. Census Brief* (1998). "Children Without Health Insurance." Washington, DC: U.S. Bureau of the Census.

[10] *New Federalism: Issues and Options for States* (1997). "Supplemental Security Income for Children with Disabilities: Part of the Federal Safety Net" (July 1997). Washington, DC: The Urban Institute.

[11] Griffen, J. (June 1998). *Health Care Needs of Children with Disabilities on Medicaid: Results of a Caregiver Survey. Final Report.* Providence, RI: MCH Evaluation, Inc.

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Women and Children Receiving WIC

DEFINITION

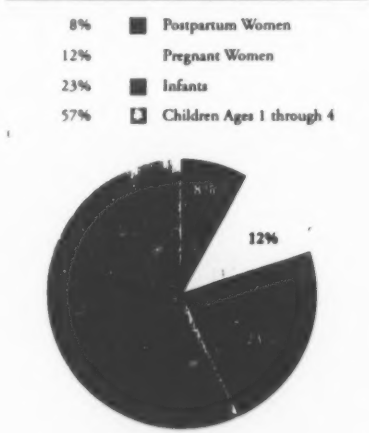
Women and children receiving WIC is the percentage of eligible women, infants and children served by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

SIGNIFICANCE

The Special Supplemental Nutrition Program for Women, Infants and Children is a preventive program providing nutritious food, nutrition education, and improved access to health care.[1] This federally-funded program serves pregnant, postpartum and breastfeeding women; infants; and children less than five years of age. Household income must be below 185% of the poverty level. In addition, any individual who participates in the Food Stamp program, RIte Care, Medicaid, cash assistance through the Family Independence Program, or is a member of a family in which a pregnant woman or infant receives Medicaid benefits, is deemed automatically income eligible.[2] Participants must have a specified health or nutritional risk, such as abnormal weight gain during pregnancy or iron deficiency anemia.

All WIC participants receive vouchers for foods such as eggs, cereal, milk, cheese, infant formula, juice, carrots, and high protein foods (beans, peanut butter, tuna fish) that can be redeemed at retail stores. The WIC Farmer's Market Nutrition Program improves the intake of fresh fruit and vegetables by providing coupons to most WIC participants to help them to purchase fresh produce at local farmers' markets.[3] In Rhode Island in 1998, nine farmers' markets provided fresh fruits and vegetables to over 10,000 recipients.[4]

Women, Infants and Children Served by WIC, Rhode Island, December 1998



Total Served is 23,278

Source: Rhode Island Department of Health, Division of Family Health, WIC Program, December 1998.

Access to WIC in Rhode Island

◆ The WIC program is closely connected to the health care delivery system. Participation in WIC increases the likelihood that women will receive early, regular prenatal care and that their children will get regular pediatric care and immunizations. Mothers and children who are poor, minority, or poorly educated benefit most.[5]

◆ WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants, and children. In December 1998, 71% of eligible women, infants and children were served across the state.[6]

◆ Four of the five cities with the highest child poverty rates — Providence, Pawtucket, Woonsocket, and Central Falls — have WIC participation rates that exceed the statewide average of 71%. In Newport, only 53% of women, infants, and children eligible for WIC are served.[7]

WIC Improves Child Nutrition and Health Status

◆ WIC links the distribution of food to other health services, including prenatal and pediatric care and education about breastfeeding. WIC promotes breastfeeding as the optimal method of infant feeding. Breastfeeding mothers qualify for a special food package and program eligibility is extended for up to one year. Thirteen out of 20 WIC sites have breastfeeding peer counselors.[8]

◆ WIC protects infants and children from iron-deficiency anemia and other nutrition-related health problems.[9] By protecting a child's cognitive development, WIC results in savings for special education that may have otherwise been incurred due to malnutrition in infancy and early childhood.[10]

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Table 10. **Women, Infants and Children Receiving WIC, Rhode Island, December 1998**

CITY/TOWN	ESTIMATED NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	211	34	16%
Bristol	403	194	48%
Burrillville	427	288	67%
Central Falls	1,642	1,380	84%
Charlestown	105	67	64%
Coventry	592	280	47%
Cranston	1,753	1,035	59%
Cumberland	554	259	47%
East Greenwich	241	57	24%
East Providence	1,205	861	71%
Exeter	13	40	100%*
Foster	10	50	100%*
Glocester	293	82	28%
Hopkinton	33	96	100%*
Jamestown	96	8	8%
Johnston	598	280	47%
Lincoln	360	174	48%
Little Compton	63	18	29%
Middletown	694	302	44%
Narragansett	71	124	100%*
Newport	1,332	710	53%
New Shoreham	39	0	0%
North Kingstown	370	219	59%
North Providence	262	403	100%*
North Smithfield	59	84	100%*
Pawtucket	3,198	2,774	87%
Portsmouth	249	124	50%
Providence	11,280	8,772	78%
Richmond	24	91	100%*
Scituate	75	59	79%
Smithfield	174	97	56%
South Kingstown	402	232	58%
Tiverton	260	148	57%
Warren	156	147	94%
Warwick	1,613	902	56%
Westerly	648	367	57%
West Greenwich	38	26	68%
West Warwick	777	617	79%
Woonsocket	2,566	1,877	73%
Core Cities	***20,018***	***15,513***	***77%***
Remainder of State	***12,868***	***7,765***	***60%***
Rhode Island	***32,886***	***23,278***	***71%***

** Estimates are based on 1990 Census, and do not reflect increases in eligible population.*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, WIC Program, December 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 5 who live in families with an income less than 185% of poverty, according to the 1990 Census of Population. This is an estimate of the eligible population and does not take into account any increases or decreases in the number of women and children who become income eligible between 1990 and 1998.

References for Indicator

[1] Duncan, G.J., Elwood, M.R., & Love, J.M. (1997). "Programs that Mitigate the Effects of Poverty on Children" in *The Future of Children: Children and Poverty*, Vol. 7, No. 2 (Summer/Fall 1997). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[2] Food Research and Action Center (1998). "Federal Food Programs: Special Supplemental Nutrition Program for Women, Infants, and Children."

[3] *Strengthening WIC Farmer's Markets: A Summary of State Strategies* (1996). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[4] Rhode Island Department of Health, Division of Family Health, WIC Program, December 1998.

[5] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[6] *Statement on the Link Between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

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Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

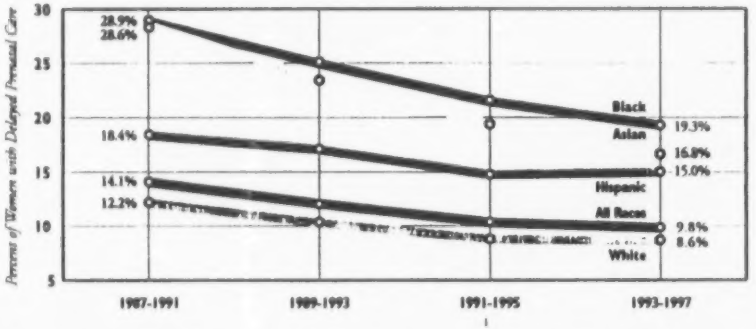
Timely and comprehensive prenatal care increases the likelihood of delivering a healthy infant of normal birthweight, results in fewer complications at birth, and reduces health care costs.[1] Delaying the start of prenatal care to the second trimester increases health risks for both mother and baby.[2] Women receiving late or no prenatal care are at increased risk of having infants who are low birthweight, who are stillborn, or who die within the first year of life.[3]

Prenatal care offers the opportunity to screen for and treat disease conditions that increase the risk for poor birth outcomes. Effective prenatal care screens for and intervenes with non-medical conditions including smoking, substance use, physical abuse, nutritional deficiencies, and needs for food, clothing and shelter.[4] Women who receive adequate prenatal care are more likely to get preventive health care for their infants.[5]

Early prenatal care is especially important for women at increased medical and social risk.[6] Several studies have indicated that low-income women who receive enhanced prenatal care services experience improved birth outcomes. Enhanced prenatal care services may include outreach, case management, risk assessment, smoking cessation, nutritional and psychosocial counseling, health education, guidance on infant and child development, referrals to WIC and other social services, and home visits.[7]

72

Delayed Prenatal Care by Race/Ethnicity, Rhode Island, 1987-1997



◆ Over the past decade, fewer women of all ethnic groups are delaying the start of prenatal care until after the first trimester of pregnancy. The percentage of Rhode Island women who did not receive prenatal care in the first trimester has decreased from 14.1% in 1987-1991 to 9.8% in 1993-1997.

◆ In Rhode Island, African-American, Asian, and Hispanic women are almost twice as likely as white women to begin prenatal care after the first trimester.[8]

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, five-year averages of data from 1987-1991, 1989-1993, 1991-1995, 1993-1997. Data for 1996 and 1997 are provisional.

Risk Factors for Delayed Prenatal Care

◆ In every race and ethnic group, mothers with more education are more likely to receive early prenatal care and to have more visits.[9]

◆ Adolescents, regardless of race, are less likely to receive early prenatal care than older mothers. In Rhode Island in 1997, more than one in four (27%) pregnant young women ages 12 to 17 years old did not receive prenatal care until after the first trimester.[10]

◆ Women who live in the core cities of Providence, Pawtucket, Woonsocket, Newport, and Central Falls are less likely to begin prenatal care in the first trimester than women who live in other communities.[11]

73

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Table 11.

Delayed Prenatal Care, Rhode Island, 1993-1997

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	802	22	2.7%
Bristol	1,224	101	8.3%
Burrillville	859	61	7.1%
Central Falls	1,674	356	21.3%
Charlestown	421	30	NA
Coventry	1,935	111	5.7%
Cranston	4,284	303	7.1%
Cumberland	1,707	96	5.6%
East Greenwich	588	26	4.4%
East Providence	2,779	209	7.5%
Exeter	382	27	NA
Foster	226	11	NA
Glocester	495	28	NA
Hopkinton	482	38	NA
Jamestown	237	7	NA
Johnston	1,597	92	5.8%
Lincoln	992	50	5.0%
Little Compton	145	9	NA
Middletown	1,250	115	9.2%
Narragansett	773	25	3.2%
Newport	1,783	222	12.4%
New Shoreham	70	5	NA
North Kingstown	1,504	84	5.6%
North Providence	1,742	119	6.8%
North Smithfield	467	25	NA
Pawtucket	5,267	781	14.8%
Portsmouth	953	41	4.3%
Providence	13,889	1,917	13.8%
Richmond	487	27	NA
Scituate	514	23	4.5%
Smithfield	859	33	3.8%
South Kingstown	1,339	67	5.0%
Tiverton	566	46	8.1%
Warren	613	48	7.8%
Warwick	4,773	291	6.1%
Westerly	1,475	147	10.0%
West Greenwich	322	13	NA
West Warwick	2,093	192	9.2%
Woonsocket	3,012	541	18.0%
Core Cities	*25,625*	*3,817*	*14.9%*
Remainder of State	*38,955*	*2,522*	*6.5%*
Rhode Island	*64,580*	*6,339*	*9.8%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1993-1997. Data for 1996 and 1997 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1993-1997. Data for 1996 and 1997 are provisional.

References for Indicator

[a] Child Trends, Inc. and the U.S. Bureau of the Census (1997). *Trends in the Well-Being of America's Children and Youth: 1997.* Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

[b] *Prenatal Care in the United States: A State and County Inventory - Volume I* (1989). New York: The Alan Guttmacher Institute.

[c] Kleman, L.V. (1991). *Alive and Well? A Research and Policy Review of Health Programs for Poor Children.* New York: Columbia University, National Center for Children in Poverty.

[d] Alexander, G.R. & Korenbrot, C.C. (1995). "The Role of Prenatal Care in Preventing Low Birth Weight" in *The Future of Children: Low Birth Weight,* Vol. 5, No. 1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[e] *Maternal and Child Health Principles in Practice: An Analysis of Select Provisions in Medicaid Managed Care Contracts* (1998). Washington, DC: Association of Maternal and Child Health Programs and George Washington University Medical Center, Center for Health Policy Research.

[f][g] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1993-1997. Data for 1996 and 1997 are provisional.

[h] National Center for Health Statistics (1998). *Health, United States, 1998.* Hyattsville, MD: U.S. Public Health Service.

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Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing under 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

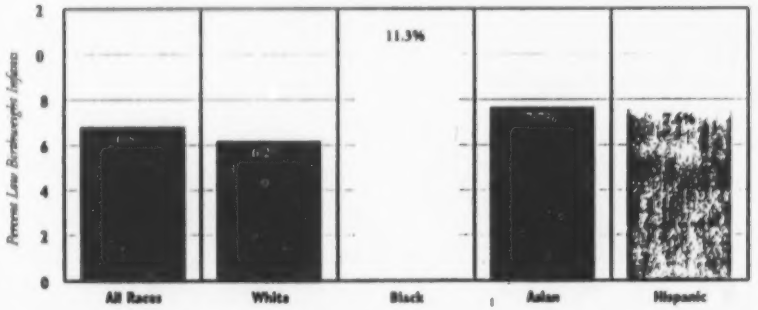
A baby's birthweight is a key indicator of newborn health and is directly related to infant survival, health and development. Babies born weighing less than 5.5 pounds are at greater risk for physical and developmental problems.[1] Low birthweight infants are a diverse group: some are born too soon (premature), some are full-term but small for their gestational age, and some are both premature and small.[2]

Low birthweight babies are at higher risk of death or long-term illness and disability than are infants of normal birthweight.[3] Low birthweight babies are twenty times more likely to die as infants.[4] Children who are now 6 to 15 years old, who were born low birthweight, are 50% more likely than children born of normal weight to be enrolled in a special education program.[5] Babies born weighing less than 1,500 grams (3.3 pounds) are at especially high risk for chronic lung and respiratory problems, visual and hearing impairments, mental retardation, and developmental and learning disabilities.[6]

Over the past decade, the rate of low birthweight babies in Rhode Island has slightly increased from 6.1% to 6.8%. During the same time period, infant death rates have decreased.[7] Changes in medical technology, improvements in neonatal intensive care, and new drug therapies for very small infants have increased the chances that even very low birthweight infants will survive.[8]

The incidence of low birthweight is strongly associated with poverty.[9] Prevention of low birthweight focuses on early and comprehensive prenatal care, adequate nutrition and weight gain, and smoking cessation. Smoking during pregnancy has been linked to 20% to 30% of low birthweight births and to long-term effects such as physical, mental, and cognitive impairments.[10]

Low Birthweight Infants by Race/Ethnicity, Rhode Island, 1993-1997



◆ Low birthweight rates for black infants in Rhode Island are almost twice those for white infants, and are higher than those for other racial groups.[11]

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1993-1997. Data for 1996 and 1997 are provisional.

◆ Nationally, black women are much more likely to have a low birthweight infant than women of any other racial or ethnic group.[12] Underlying the high rate of low birthweight infants among African-Americans in the U.S. is the higher rate of preterm delivery (babies born before 37 weeks gestation).[13]

◆ The higher rates of low birthweight and preterm delivery among African-American women are not well understood; the higher rates are not completely explained by differences in socio-economic status, education, health status, or use of tobacco or other drugs.[14,15]

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Table 12 Low Birthweight Infants, Rhode Island, 1993-1997

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	802	55	6.9%
Bristol	1,224	83	6.8%
Burrillville	859	43	5.0%
Central Falls	1,674	143	8.5%
Charlestown	421	20	NA
Coventry	1,935	121	6.3%
Cranston	4,284	298	7.0%
Cumberland	1,707	89	5.2%
East Greenwich	588	36	6.1%
East Providence	2,779	191	6.9%
Exeter	382	16	NA
Foster	226	16	NA
Glocester	495	35	NA
Hopkinton	482	28	NA
Jamestown	237	13	NA
Johnston	1,597	108	6.8%
Lincoln	992	47	4.7%
Little Compton	145	7	NA
Middletown	1,250	48	3.8%
Narragansett	771	41	5.3%
Newport	1,783	119	6.7%
New Shoreham	70	3	NA
North Kingstown	1,504	76	5.1%
North Providence	1,742	135	7.7%
North Smithfield	467	27	NA
Pawtucket	5,267	382	7.3%
Portsmouth	953	43	4.5%
Providence	13,889	1164	8.4%
Richmond	487	17	NA
Scituate	514	40	7.8%
Smithfield	859	34	4.0%
South Kingstown	1,339	68	5.1%
Tiverton	566	32	5.7%
Warren	613	38	6.2%
Warwick	4,773	272	5.7%
Westerly	1,475	81	5.5%
West Greenwich	322	17	NA
West Warwick	2,093	170	8.1%
Woonsocket	3,012	226	7.5%
Core Cities	*25,625*	*2,034*	*7.9%*
Remainder of State	*38,955*	*2,348*	*6.0%*
Rhode Island	*64,580*	*4,382*	*6.8%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1993-1997. Data for 1996 and 1997 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1993-1997.

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References for Indicator

"Children's Defense Fund (1996). "Infant Health Improving" in *CDF Reports*, Vol. 17, No. 12 (November 1996). Washington, DC: Children's Defense Fund.

" *America's Children: Key National Indicators of Well-Being* (1998). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

' Lewit, E., Schaumann Baker, L., Corman, H., Shiono, P.H. (1995). "The Direct Cost of Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucille Packard Foundation.

° Vohr, B.R. & Msall, M.E. (1997). "Neuropsychological and Functional Outcomes of Very Low Birthweight Infants" in *Seminars in Perinatology*, Vol. 21, No. 4 (June 1997); and Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucille Packard Foundation.

' Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1987-1991 and 1993-1997. Data for 1996 and 1997 are provisional.

* Lewit, E., Schaumann Baker, L., Corman, H., & Shiono, P.H. (1995). "The Direct Cost of Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children; and Shiono, P.H., & Behrman, R.E. (1995). "Low Birth Weight: Analysis and Recommendations" in The Future of Children: Low Birthweight, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children.

° ° ° Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucille Packard Foundation.

" Chomitz, V.R., Cheung, L.W.Y., Lieberman, E., "The Role of Lifestyle in Preventing Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children.

" Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1993-1997. Data for 1996 and 1997 are provisional.

" " *National Vital Statistics Reports*, Volume 47, Number 4 (October 7, 1998). Washington, DC: Centers for Disease Control, National Center for Health Statistics, National Vital Statistics System.

Infant Mortality

DEFINITION

Infant mortality is the number of deaths occurring to infants under one year of age per 1,000 live births. The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Infant mortality rates are closely linked to a community's social and economic conditions. Communities with multiple problems such as poverty, poor housing conditions, and unemployment tend to have higher infant mortality rates than more advantaged communities.[1] Risk factors contributing to infant deaths include a lack of preventive health care for women before and during pregnancy, inadequate nutrition, and poor living conditions. Some of the health factors associated with infant deaths include congenital birth defects, complications resulting from early delivery and low birthweight, and respiratory problems.[2]

In the United States, about two-thirds of infant deaths occur in the first month after birth and are connected closely to low birthweight, preterm delivery, or birth defects; about one-third occur after the first month and are associated with social or environmental factors, such as poverty, health care quality and access, or poor living conditions.[3,4]

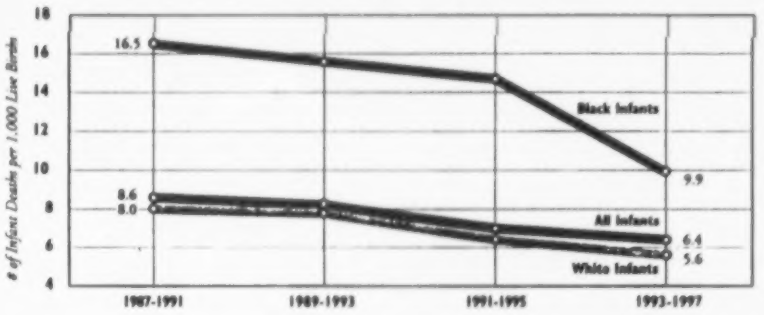
Infant mortality has two components: neonatal mortality, which is the number of deaths of infants younger than 28 days, and postneonatal mortality, the number of deaths of infants between 28 days and one year old. In 1997 in Rhode Island, 87 infants died before their first birthday; of these, 69 were younger than 28 days old. Twenty-nine were live births less than 500 grams (1.1 pounds).[5]

U.S. Infant Mortality Rate Ranks Behind Other Countries

◆ 1997 preliminary data for the U.S. shows an infant mortality rate of 7.1, a record low for the nation.[6]

◆ In 1997, the overall United States infant mortality rate ranked twenty-eighth worldwide. The U.S. infant mortality rate for black infants (13.7 deaths per 1,000 births) ranks forty-fourth when compared with other countries overall rates.[7]

Infant Mortality by Race, Rhode Island, 1987-1997



◆ Over the past ten years, infant mortality rates for all racial groups in Rhode Island have declined.

◆ Rhode Island's infant mortality rate has improved from 8.6 infant deaths per 1,000 births in 1987-1991 to 6.4 infant deaths per 1,000 births in 1993-1997.

◆ Significant progress has been made in closing the gap in the infant mortality rate between black infants and those of other racial and ethnic groups. The death rate for black infants in Rhode Island has declined by 40% over the past decade.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, five-year averages of data from 1987-1991, 1989-1993, 1991-1995 and 1993-1997. Data for 1996 and 1997 are provisional.

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Table 13.

Number of Infant Deaths, Rhode Island, 1993-1997

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	802	2	2.5
Bristol	1,224	5	4.1
Burrillville	859	7	8.1
Central Falls	1,674	18	10.8
Charlestown	421	2	NA
Coventry	1,935	8	4.1
Cranston	4,284	25	5.8
Cumberland	1,707	10	5.9
East Greenwich	588	2	3.4
East Providence	2,779	14	5.0
Exeter	382	1	NA
Foster	226	0	NA
Glocester	495	5	NA
Hopkinton	482	1	NA
Jamestown	237	0	NA
Johnston	1,597	6	3.8
Lincoln	992	2	2.0
Little Compton	145	0	NA
Middletown	1,250	8	6.4
Narragansett	773	3	3.9
Newport	1,783	9	5.0
New Shoreham	70	0	NA
North Kingstown	1,504	11	7.3
North Providence	1,742	9	5.2
North Smithfield	467	4	NA
Pawtucket	5,267	31	5.9
Portsmouth	953	6	6.3
Providence	13,889	129	9.3
Richmond	487	2	NA
Scituate	514	2	3.9
Smithfield	859	3	3.5
South Kingstown	1,339	9	6.7
Tiverton	566	4	7.1
Warren	613	1	1.6
Warwick	4,773	27	5.7
Westerly	1,475	9	6.1
West Greenwich	322	0	NA
West Warwick	2,093	18	8.6
Woonsocket	3,012	21	7.0
Core Cities	*25,625*	*208*	*8.1*
Remainder of State	*38,955*	*206*	*5.3*
Rhode Island	*64,580*	*414*	*6.4*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1993-1997. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls. Data for 1996 and 1997 are provisional.

NA: Rates were not calculated for cities and towns with less than 500 births, as rates for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1993-1997.

References for Indicator

[1] *The State of the World's Children: 1999* (1999). New York: United Nations Children's Fund (UNICEF).

[2] Kleiman, Lorraine V., *Alive and Well? A Research and Policy Review of Health Programs for Poor Children* (1991). New York: Columbia University, National Center for Children in Poverty.

[3] *America's Children: Key National Indicators of Well-Being* (1998). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[4] Paneth, N.S. (1995). "The Problem of Low Birth Weight" in *The Future of Children: Low Birth Weight*, Vol.5, No.1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[5] Provisional 1997 data on 12,076 births, Rhode Island Department of Health, Office of Vital Statistics, January 1999.

[6] *National Vital Statistics Reports*, Volume 47, Number 4 (October 7, 1998). Washington, DC: Centers for Disease Control, National Center for Health Statistics, National Vital Statistics System.

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Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old children screened for lead poisoning who had elevated blood lead levels (10 ug/dL) at any time prior to November 30, 1998. These data are for children eligible to enter kindergarten in the fall of 2000 (i.e. born between September 1, 1994 and August 31, 1995).

SIGNIFICANCE

Childhood lead poisoning is one of the most common pediatric health problems and is entirely preventable. Infants, toddlers, and pre-school age children are most susceptible to the toxic effects of lead. Lead's effects on the developing central nervous system may be irreversible.[1] Learning disabilities, hyperactivity, antisocial behavior, attention deficit disorder, hearing and speech impediments, and loss of intelligence can be attributed to lead levels equal to or greater than 10 ug/dL. Higher levels of lead exposure can result in serious health problems and can lead to coma, convulsions, and death.[2,3]

A strong link has been established between low level lead exposure in early childhood and later decreased academic performance. The duration of the exposure is as important as the severity of the exposure in predicting later effects. Children with chronic exposure are more likely to have lowered IQ, behavioral problems, and as a result, academic failure and increased risk for juvenile delinquency.[4] Strategies that prevent lead exposure, intervene early when exposure is evident, and provide health and child development services to affected children are critical to improving long-term health and educational outcomes.[5]

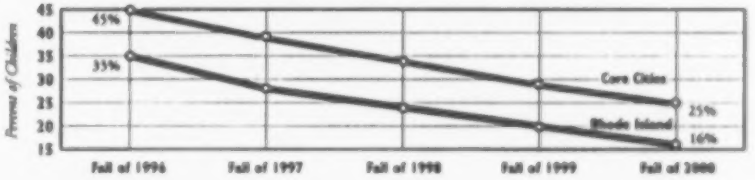
While all children are at risk for lead poisoning, low-income children and minority children are particularly likely to be affected.[6,7] Inadequate nutrition and anemia, more common in low-income children, further increase a child's susceptibility to lead poisoning.[8]

◆ In 1998, sixty-eight percent of all Rhode Island children under age six screened with high lead levels lived in one of the core cities.[9]

◆ One in four children screened in Providence and Central Falls in 1998 had high lead levels, compared to just over one in ten statewide.[10]

◆ In 1998, eleven Rhode Island children were hospitalized with seriously high lead levels. Of these, 6 were from Providence, 2 were from Central Falls, and 3 were from Woonsocket.[11]

Percentage of Children Entering Kindergarten with Elevated Blood Levels (greater than or equal to 10 ug/dL), Core Cities and Rhode Island, 1996-2000



◆ Progress has been made in reducing the numbers of children in Rhode Island with lead exposure. 35% (3,910) of children eligible to enter kindergarten in the fall of 1996 had been screened with a blood lead level over 10 ug/dL as compared to 16% (2,327) of children eligible to enter kindergarten in the fall of 2000.

Source: RI Department of Health, Office of Health Risk Assessment and Division of Family Health. Data are based on nearly universal screening of the kindergarten cohorts for 1996 (n=11,056); 1997 (n=15,257); 1998 (n=16,440); 1999 (n=15,422); and 2000 (n=14,497)

Lead Exposure Linked to Poor Housing Conditions

◆ The lack of affordable housing in many communities means that many low-income families live in older dwellings with deteriorating lead paint, placing children at risk for lead poisoning.[12]

◆ Rhode Island is the first state to get permission to use state and federal Medicaid money for replacing or fixing windows in the homes of lead poisoned children covered by RIte Care. The funds will be offset by the savings from lower treatment and hospitalization costs.[13]

◆ Window replacement funds in Rhode Island will be coordinated through community-based Lead Safe Centers that provide a comprehensive lead clinic, case management, parent-to-parent education, and housing advocacy for families with lead levels over 20ug/dL. In 1998 there were 739 children with lead levels over 20 ug/dL; almost half of these children (48%) lived in Providence.[14]

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Table 14.
Lead Poisoning in Children Entering Kindergarten in the Fall of 2000

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	229	11	4.8%
Bristol	291	23	7.9%
Burrillville	226	28	12.4%
Central Falls	390	92	23.6%
Charlestown	94	7	7.4%
Coventry	389	26	6.7%
Cranston	836	94	11.2%
Cumberland	396	28	7.1%
East Greenwich	168	8	4.8%
East Providence	584	46	7.9%
Exeter	93	6	6.5%
Foster	58	3	5.2%
Glocester	97	14	14.4%
Hopkinton	72	9	12.5%
Jamestown	45	6	13.3%
Johnston	266	25	9.4%
Lincoln	221	19	8.6%
Little Compton	31	4	12.9%
Middletown	189	17	9.0%
Narragansett	204	15	7.4%
Newport	374	69	18.4%
New Shoreham	10	1	10.0%
North Kingstown	351	27	7.7%
North Providence	302	31	10.3%
North Smithfield	112	4	3.6%
Pawtucket	1,273	219	17.2%
Portsmouth	207	19	9.2%
Providence	3,031	942	31.1%
Richmond	97	9	9.3%
Scituate	116	7	6.0%
Smithfield	142	11	7.7%
South Kingstown	327	33	10.1%
Tiverton	180	21	11.7%
Warren	160	22	13.8%
Warwick	947	56	5.9%
Westerly	156	22	14.1%
West Greenwich	72	2	2.8%
West Warwick	414	49	11.8%
Woonsocket	796	138	17.3%
Unknown Residence	*551*	*164*	*NA*
Core Cities	*5,864*	*1,460*	*24.9%*
Remainder of State	*8,082*	*703*	*8.7%*
Rhode Island	*14,497*	*2,327*	*16.1%*

Source of Data for Table/Methodology

Rhode Island Department Health, Office of Health Risk Assessment and Division of Family Health, November 1998.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

Data for children entering kindergarten in the Fall of 2000 reflects the number of RI children eligible to enter school in the fall of 2000 (i.e. born between 9/1/94 and 8/31/95) who screened positive for lead poisoning at anytime prior to November 30, 1998. Rhode Island law requires universal lead screening for children under six. Lead screening results for close to 100% of Rhode Island children in this age cohort are included in this indicator.

The denominator is the number of children entering school in the fall of 2000 who were screened for lead poisoning.

References for Indicator

[1,2,3,4,5] Centers for Disease Control and Prevention (1997). *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials* (November 1997). Atlanta: Centers for Disease Control and Prevention.

[2] Pueschel, S.M., Linakis, J.G., and Anderson, A.C. (1996). *Lead Poisoning in Childhood.* Baltimore: Paul H. Brookes Publishing Co.

[4] *Coordinating Care from Clinic to Community: Quality Standards for Serving Children and Families Affected by Environmental Lead Hazards* (1998). Boston: New England Serve.

[7] Child Trends, Inc. and the U.S. Bureau of the Census (1997). *Trends in the Well-Being of America's Children and Youth: 1997.* Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

[8,10] Rhode Island Department of Health, Office of Health Risk Assessment and Division of Family Health, July 1, 1997- June 30, 1998.

[9] Rhode Island Department of Health, Division of Family Health, January 1998 - December 1998.

[11] Lead-Based Paint Hazard Reduction and Financing Task Force (1995). *Putting the Pieces Together: Controlling Lead Hazards in the Nation's Housing* (Summary, June 1995). Washington, DC: U.S. Department of Housing and Urban Development; and National Center for Lead-Safe Housing, (1992). *Childhood Lead Poisoning and Affordable Housing: An Overview.* September 1992 [newsletter].

[12] Herzog, D., "Medicaid to help abate lead paint on windows," Providence Journal Bulletin, Friday, December 11, 1998.

[13] Rhode Island Department of Human Services, January 1999 and Rhode Island Department of Health, Office of Health Risk Assessment and Division of Family Health, July 1, 1997- June 30, 1998.

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Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 17 per 1,000 teen girls. Data are reported by the mother's place of residence, not the place of the infant's birth.

SIGNIFICANCE

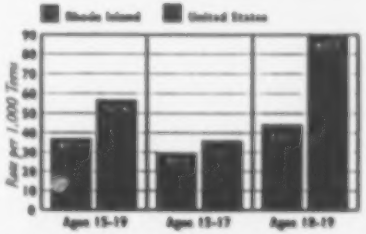
Teen pregnancy and parenting threatens the development of teen parents as well as their children. Teen mothers are less likely to obtain adequate prenatal care and are less likely to have financial resources and social supports needed for healthy child development.[1] Children born to teen parents are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison, and become teen parents themselves.[2]

Poor academic achievement is a key predictor of teen pregnancy.[3,4] Nationally, three out of five teen mothers drop out of school.[5] Being a teen parent seriously limits subsequent education and employment prospects.[6] Teen parents are more likely to delay or not finish school, putting them at greater risk of facing unemployment, low-wage jobs, and poverty. Teen moms are more likely to have mothers who have completed fewer years of schooling and to have mothers or older sisters who also gave birth as adolescents.[7]

While teen pregnancy occurs in families of all income levels, teens who give birth are more likely to come from economically disadvantaged families and communities.[8] In the U.S., 83% of teens who give birth and 61% of teens who have abortions are from poor or low-income families.

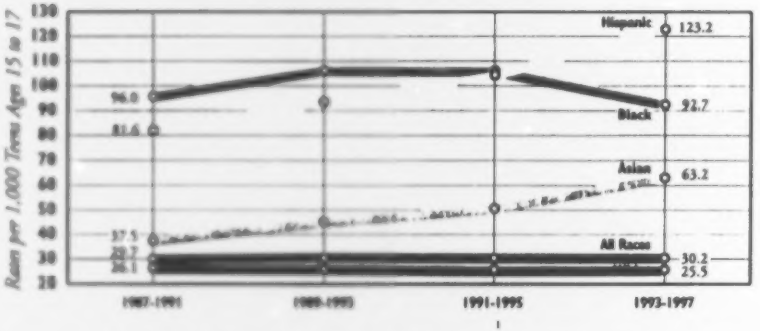
In Rhode Island between 1993 and 1997, there were 141 babies born to girls age 12 to 14 and 2,611 babies born to girls age 15 to 17. Two out of three births to teens ages 15 to 17 were to girls in the cities of Providence, Pawtucket, Woonsocket, Newport and Central Falls.[10] In Rhode Island in 1996, almost one in four (22%) births to teen girls ages 15 to 19 were repeat births. Rhode Island ranks in the bottom quarter of states for repeat births to teens — 36th in the country.[11]

Birth Rates by Age, Rhode Island and United States, 1995



◆ Rhode Island's teen birth rate is significantly lower than the national rate, largely due to the lower birth rate among older teens ages 18 to 19.[12]

Birth to Teens, Ages 15-17, by Race/Ethnicity, Rhode Island, 1987-1997



◆ Since the late 1980s, the teen birth rate for Rhode Island girls ages 15 to 17 remained steady at approximately 30 births per 1,000 teens.

◆ The birth rate for black teens ages 15 to 17 decreased from 96.0 births per 1,000 teen girls in 1987-1991 to 92.7 births per 1,000 teen girls in 1993-1997.

◆ The birth rates for Asian teens increased from 37.5 births per 1,000 teens in 1987-1991 to 63.2 births per 1,000 teens in 1993-1997. The birth rate for Hispanic teens increased from 81.6 births per 1,000 teens in 1987-1991 to 123.2 births per 1,000 teens in 1993-1997.

Source: Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, five-year averages of data from 1987-1991, 1989-1993, 1991-1995, 1993-1997. Data for 1996 and 1997 are provisional. Hispanic data are not available for 1987 and 1988.

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Table 15.

Births to Teens, Age 15-17, Rhode Island, 1993-1997

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	RATE PER 1,000 TEENS
Barrington	1,410	8	5.7
Bristol	1,845	24	13.0
Burrillville	1,605	21	13.1
Central Falls	1,545	108	69.9
Charlestown	485	11	NA
Coventry	3,065	46	15.0
Cranston	5,685	100	17.6
Cumberland	2,740	32	11.7
East Greenwich	1,360	5	3.7
East Providence	4,320	68	15.7
Exeter	585	9	15.4
Foster	450	3	NA
Glocester	1,030	6	5.8
Hopkinton	670	10	14.9
Jamestown	400	3	NA
Johnston	2,225	27	12.1
Lincoln	1,610	16	9.9
Little Compton	255	3	NA
Middletown	1,470	25	17.0
Narragansett	1,020	8	7.8
Newport	1,950	103	52.8
New Shoreham	25	0	NA
North Kingstown	2,385	30	12.6
North Providence	2,575	40	15.5
North Smithfield	1,165	6	5.2
Pawtucket	6,430	268	41.7
Portsmouth	1,710	14	8.2
Providence	13,395	1,087	81.1
Richmond	510	15	29.4
Scituate	1,080	5	4.6
Smithfield	1,430	7	4.9
South Kingstown	1,830	33	18.0
Tiverton	1,405	17	12.1
Warren	910	18	19.8
Warwick	7,275	117	16.1
Westerly	1,785	41	23.0
West Greenwich	365	3	NA
West Warwick	2,400	69	28.8
Woonsocket	3,995	205	51.3
Core Cities	*27,315*	*1,771*	*64.8*
Remainder of State	*59,080*	*840*	*14.2*
Rhode Island	*86,395*	*2,611*	*30.2*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1993-1997. Data for 1996 and 1997 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Rates were not calculated for cities and towns with less than 100 births, as rates for small denominators are statistically unreliable.

The denominator is the number of girls ages 15 through 17 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1993-1997.

References for Indicator

[1] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[2] *The State of America's Children Yearbook 1995* (1995). Washington, DC: Children's Defense Fund.

[3] *When Teens Have Sex: Issues and Trends, Kids Count Special Report* (1998). Baltimore, MD: The Annie E. Casey Foundation.

[4] [5] *Why the Education Community Cares About Preventing Teen Pregnancy: Notes from the Field* (1998). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[6] Child Trends, Inc. and the U.S. Census Bureau (1996). *Trends in the Well-Being of America's Children and Youth: 1996*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[7] *Facts in Brief: Teen Sex and Pregnancy* (1997). New York: Alan Guttmacher Institute.

[8] Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1993-1997. Data for 1996 and 1997 are provisional.

[9] Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1993-1997 average. Data for 1996 and 1997 are provisional; and, *National Vital Statistics Reports* (1998). Vol. 47, No. 12. "Declines in Teenage Birth Rates, 1991-1997: National and State Patterns." Washington, DC: National Center for Health Statistics. National data are provisional from 1995.

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Alcohol, Drug, and Cigarette Use by Teens

DEFINITION

Alcohol, drug, and cigarette use by teens is the percentage of seventh-grade, ninth-grade, and twelfth-grade students who have used alcohol, marijuana, or cigarettes in the past month, based on the 1998 Rhode Island Adolescent Substance Abuse Survey.

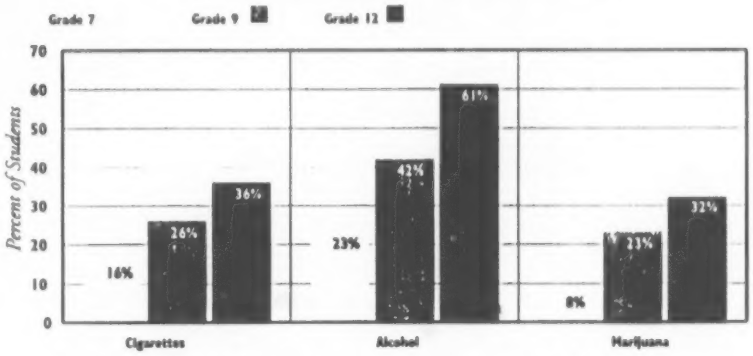
SIGNIFICANCE

The use of substances threatens the health and safety of children, families, and communities. Abuse of alcohol and drugs is implicated in unemployment, worker absenteeism, accidents, vandalism, fires, damaged and destroyed playgrounds and housing, violent crimes, poverty, and homelessness.[1] Children and teens are negatively affected by the emotional and financial hardships caused by parents with substance abuse problems.[2] 18% of Rhode Island seventh to twelfth graders surveyed in 1998 reported that the drinking of one or both of their parents caused problems.[3]

Young people who abuse alcohol and drugs are more likely to drop out of school, become teen parents, engage in high-risk sexual behavior, experience injuries, and become involved with the criminal justice system.[4] Substance use has been shown to cause dependency, mood changes, impaired judgment, memory loss, and prolonged aimlessness.[5] Suicide, homicides, and unintentional injuries account for approximately 80% of U.S. adolescent deaths. Many of these deaths involve alcohol and drugs.[6] Studies show that about 30% of drivers ages 15 to 20 who were involved in fatal crashes were under the influence of alcohol.[7]

The younger people start smoking cigarettes, the more likely they are to become strongly addicted to nicotine. 89% of adult daily smokers tried their first cigarette by age 18.[8] Smoking has serious long-term consequences, including the risk of smoking-related diseases, increased health care costs associated with treating these illnesses, and the risk of premature death. It is estimated that more than five million of today's underage smokers will die of tobacco-related illnesses.[9]

Use* of Cigarettes, Alcohol, and Marijuana, by Student Grade Level, Rhode Island, 1998



**Student has smoked at least one cigarette in the past month or has used alcohol or marijuana in the past month. Based on a survey of 5,644 students in seventh grade; 4,350 students in ninth grade; and 2,401 students in twelfth grade.*

- Almost one in four (23%) Rhode Island seventh-grade students reported using alcohol in the past month. Almost half (42%) of ninth graders and almost two-thirds (61%) of twelfth graders reported using alcohol in the past month.
- 26% of ninth graders and 36% of twelfth graders had smoked at least one cigarette in the past month. Almost half of all students reported that one or both parents smoked.
- 23% of ninth graders and 32% of twelfth graders reported using marijuana at least once in the past month.
- Alcohol is the leading substance of abuse at all grade levels in Rhode Island. The prevalence of alcohol use among Rhode Island students is higher than national rates.
- In Rhode Island in 1998, 16% of eighth graders reported being drunk in the past month, and 41% of twelfth graders reported being drunk in the past month.

Source: *The 1998 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results* (1999). Providence: Rhode Island Department of Health, Office of Health Statistics.

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Alcohol, Drug, and Cigarette Use by Teens

Developmental Assets Reduce Teen Risk Behaviors

◆ Preventing substance abuse, smoking, and other adolescent risk behaviors requires an approach that starts before the teen years and helps children and young adolescents develop critical life skills and supportive relationships.[10]

◆ Research by the Search Institute has identified forty developmental assets for positive youth development. These assets include family, community, and individual factors which help youth grow up healthy, caring, and responsible.[11]

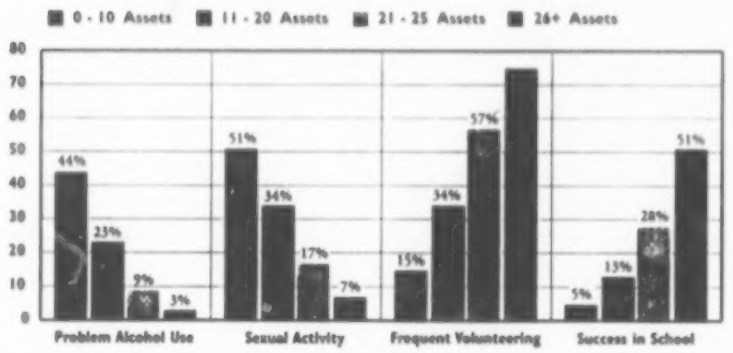
◆ Thirteen of the forty developmental assets identified by the Search Institute are as follows:

Support: strong family support; positive family communication; support from three or more nonparent adults; caring neighborhood and school climate; actively involved parent in the youth's schooling.

Empowerment: strong community value of youth; youth are given useful roles in the community; youth serve the community one or more hours a week; the young person feels safe at home, school, and in the neighborhood.

Boundaries and Expectations: the youth has strong boundaries in school, at home, and in the neighborhood; has positive adult role models; positive peer influence; and high expectations.

Percentage of 6th to 12th Graders Who Report Each Behavior by Number of Developmental Assets They Experience



Source: *Forty Developmental Assets* (1997). Minneapolis, MN: The Search Institute.

References for Indicator

[1] *1996 National Survey of American Attitudes and Substance Abuse II* (1996). National Center on Addiction and Substance Abuse: Columbia University.

[2] *America's Children at Risk: A National Agenda for Legal Action* (1993). Chicago: American Bar Association.

[3] *The 1998 Rhode Island Adolescent Substance Abuse Survey. Report of Statewide Results* (1999). Providence: Rhode Island Department of Health, Office of Health Statistics.

[4] *Sex and America's Teenagers* (1994). New York: Alan Guttmacher Institute.

[5] Perry, C.L. (1996). "Models for Effective Prevention" in *The Prevention Researcher*, Vol.3, No.1 (Winter, 1996).

[6] Child Trends, Inc. and the U.S. Census Bureau (1996). *Trends in the Well Being of America's Children and Youth: 1996*. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[8] *Preventing Tobacco Use Among Young People: A Report of the Surgeon General* (1994). Atlanta: The Centers for Disease Control and Prevention.

[9] *America's Children: Key National Indicators of Well Being* (1998). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[10] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

[11] *Forty Developmental Assets* (1997). Minneapolis, MN: The Search Institute.

94

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Children with Asthma

DEFINITION

Children with asthma is the annual number of hospitalizations for asthma among children under age 18. Data are reported by place of child's residence at the time of hospitalization.

SIGNIFICANCE

Asthma is a chronic breathing disorder and one of the most common chronic health problems among children.[1] Many asthma attacks occur when children get respiratory infections, including those caused by common cold viruses. Asthma can be triggered by: exposure to cigarette smoke, dust in the home, stress, strenuous exercise, allergies, roach infestation, indoor and outdoor air pollutants, and weather conditions.[2]

Medical care that is accessible and timely can prevent severe episodes of asthma in many cases. Hospitalization for asthma may indicate that the child has not had adequate outpatient management for the disease.[3] Children with asthma that is not managed well are more likely to miss school and to be hospitalized for symptoms that could have been prevented. Parents are more likely to miss work and to incur additional medical expenses associated with recurring medical visits and follow-up care.[4] National studies indicate that most of the potentially avoidable hospitalizations of children younger than age 15 are for pneumonia or asthma.[5]

Asthma is more common in families living in poverty or in crowded housing.[6] Children living in communities with a median family income below $20,000 are twice as likely to be hospitalized with asthma as those living in neighborhoods with an income of at least $40,000. Asthma hospitalization rates are three times higher among black children than among white children.[7]

Hospitalizations for Childhood Asthma, Core Cities and Rhode Island, 1997

City/Town	Number of Children Hospitalized	Rate per 1,000 Children
Providence	189	4.2
Woonsocket	43	3.8
Newport	15	2.4
Pawtucket	38	2.1
Central Falls	10	1.8
Total Core Cities	295	3.4
Rhode Island	619	2.6

Source: Rhode Island Department of Health, Hospital Discharge Database, 1998. Data are for Fiscal Year 1997, from July 1, 1996 to June 30, 1997.

Childhood Asthma in the United States

◆ Asthma is the most common chronic disease in childhood.[8] Nationally, approximately 10% of children have symptoms consistent with asthma and nearly 5 million children under age 18 have asthma.[9]

◆ The U.S. death rate from asthma for children 19 years and younger increased by 78% between 1980 and 1993.[10]

◆ Children under age 14 are more likely than teens and adults to receive asthma care in the outpatient department; adolescents and young adults are more likely than other age groups to visit the emergency room for asthma treatment.[11]

◆ Managing asthma requires a long-term, multifaceted approach, including patient education, behavior changes, avoidance of asthma triggers, medicines to minimize and prevent symptoms, prompt treatment, and frequent medical follow-up.[12]

Hospitalizations for Childhood Asthma, Rhode Island, July 1, 1996 to June 30, 1997

◆ More than twenty-percent of all child hospitalizations in Rhode Island were for respiratory-related reasons; of these, almost one-third were for asthma.

◆ Of the 619 asthma hospitalizations of Rhode Island children: 44% were for children under age 5; 26% were for children ages 5 to 9; 21% were for children ages 10 to 14; and 9% were for children ages 15 to 17.

◆ Almost half (48%) of all hospitalizations for childhood asthma were in the core cities of Providence, Pawtucket, Woonsocket, Newport, and Central Falls, which also have the highest child poverty rates in the state.

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Table 16.

Asthma Hospitalizations for Children, Rhode Island, 1997

CITY/TOWN	ESTIMATED NUMBER OF CHILDREN UNDER 18	NUMBER OF ASTHMA HOSPITALIZATIONS	RATE/1000 CHILDREN
Barrington	3,582	4	1.1
Bristol	4,520	11	2.4
Burrillville	4,039	12	3.0
Central Falls	5,681	10	1.8
Charlestown	1,707	6	3.5
Coventry	7,317	20	2.7
Cranston	15,361	41	2.7
Cumberland	6,362	8	1.3
East Greenwich	2,535	4	1.6
East Providence	10,620	26	2.4
Exeter	1,481	2	1.4
Foster	1,091	3	2.8
Glocester	2,239	1	0.4
Hopkinton	1,855	2	1.1
Jamestown	1,066	1	0.9
Johnston	5,658	14	2.5
Lincoln	3,854	9	2.3
Little Compton	680	0	0.0
Middletown	4,920	8	1.6
Narragansett	2,949	9	3.1
Newport	6,285	15	2.4
New Shoreham	213	2	NA
North Kingstown	5,847	4	0.7
North Providence	6,005	20	3.3
North Smithfield	1,961	5	2.5
Pawtucket	18,480	38	2.1
Portsmouth	3,922	4	1.0
Providence	45,240	189	4.2
Richmond	1,638	7	4.3
Scituate	2,218	6	2.7
Smithfield	3,692	9	2.4
South Kingstown	4,871	13	2.7
Tiverton	2,781	0	0.0
Warren	2,511	1	0.4
Warwick	18,177	40	2.2
Westerly	5,383	17	3.2
West Greenwich	978	5	5.1
West Warwick	7,194	10	1.4
Woonsocket	11,330	43	3.8
Core Cities	*87,016*	*295*	*3.4*
Remainder of State	*149,219*	*324*	*2.2*
Rhode Island	*236,234*	*619*	*2.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 1998. Data are for Fiscal Year 1997, from July 1, 1996 to June 30, 1997.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the number of children ages one to ten according to the 1990 Census of Population, plus seven times the average number of births for the years 1991 to 1997, minus the average number of deaths for the same years.

References for Indicator

[1] *Childhood Asthma* (1997). Milwaukee: American Academy of Allergy, Asthma, and Immunology.

[2,3] National Center for Health Statistics (1998). *Health, United States, 1998 With Socioeconomic Status and Health Chartbook.* Hyattsville, MD: US Department of Health and Human Services.

[4] *Trends in the Well-Being of America's Children and Youth: 1997.* Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation and Child Trends, Inc.

[5] *Health Insurance Coverage Leads to Increased Health Care Access for Children* (1997). Washington, DC: Government Accounting Office.

[6] Klerman, L. V. (1991). *Alive and Well? A Research and Policy Review of Health Programs for Poor Children.* New York, NY: Columbia University, National Center for Children in Poverty.

[7,8,9] *CDC's Asthma Prevention Program* (1997). Atlanta: Centers for Disease Control and Prevention, National Center for Environmental Health.

[10] National Center for Health Statistics (1996). *Ambulatory Care Visits for Asthma: United States 1993-1994.* Atlanta: Centers for Disease Control and Prevention.

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Additional Children's Health Issues

Rhode Island KIDS COUNT is dedicated to providing a comprehensive profile of the well-being of children in Rhode Island. However, there are some important issues affecting children for which there is a lack of available city and town data. Some of these critical health issues are as follows:

Access to Dental Care

◆ Access to dental care is a major obstacle confronting children from poor, working poor, and uninsured families. Minorities have the greatest extent of untreated dental problems for all age groups.[1]

◆ Children who receive an inadequate level of dental care or no dental care at all can develop long-term oral health problems and are more likely to experience dental conditions that require emergency treatment.[2] Chronic dental problems can lead to a poor self-image, a lack of concentration, absenteeism, and reduced school performance.[3]

◆ In 1996, only 28% of children under age 14 enrolled in RIte Care received sealants. The Centers for Disease Control recommends that 50% of children receive dental sealants. Children with sealants have significantly less untreated dental decay than children without sealants.[4]

RIte Care Dental Providers in Rhode Island

◆ Low reimbursement rates and the high no show rate among RIte Care recipients are significant barriers to provider participation. Participation in RIte Care at any significant level can be a financial burden for some dentists. Several regions of Rhode Island have limited providers serving RIte Care enrollees and few dental specialists participate in the RIte Care program.[5]

◆ Statewide, there are 113 RIte Care enrollees for each RIte Care dentist. This is an overestimate of dental access, because participating dentists may place severe limits on the number of Medicaid clients they will accept; some serve no Medicaid clients. In Woonsocket, Pawtucket, and Providence there are more than 220 RIte Care enrollees per dental provider. In Central Falls, there are over 1,000 RIte Care enrollees for every dental provider.[6]

◆ Five community health centers in the state provide dental care, and all have waiting lists for new patients. Community health centers represent less than 2 percent of dental providers listed as participating in the Medicaid program, yet they deliver approximately 20% of the dental visits to RIte Care members age 14 and under.[7]

◆ Dental screenings and services are available through Head Start, Donated Dental Services of Rhode Island (for children with disabilities), Traveler's Aid program for homeless teens. In Providence, expansions of the targeted school-based sealant program and the dental clinic at St. Joseph's Hospital have increased access for low-income and immigrant children.

References

[1] Zimmerman, H. (1996). *Dental Care and Unmet Needs for Dental Care Among the Uninsured and Medicaid Populations of Rhode Island.* Rhode Island: Rhode Island Health Care Association.

[2] *Caring Prescriptions: Comprehensive Health Care Strategies for Children in Poverty* (1993). New York: Columbia University, National Center for Children in Poverty.

[3] "Child Indicators: Dental Health" in *The Future of Children* (Spring 1998). Los Altos: The Center for the Future of Children.

[4] [5] [6] [7] *Study of Alternatives for Delivery of Medicaid Dental Services* (1998). Cranston, RI: Rhode Island Department of Human Services.

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Child Immunizations

◆ Children need to be immunized on schedule to guard against a variety of preventable illnesses. It is estimated that every dollar spent on immunization saves ten dollars in later medical costs.[1]

◆ The 1997 National Immunization Survey conducted by the CDC shows that 78% of U.S. children aged 19-35 months were immunized.[2]

◆ In 1997, Rhode Island's immunization rate for 19 to 35 months-olds was 84%. Rhode Island is ranked seventh best in the nation.[3]

◆ Children with family incomes below the poverty level are less likely to receive the combined series of immunizations than children with family incomes at or above the poverty level.[4]

◆ Retrospective surveys conducted by the Rhode Island Department of Health reveal significant discrepancies in the completeness of immunizations between children in low-income communities and the rest of the state. These discrepancies appear as early as three months of age, widen by seven months, and persist throughout the first two years of life.[5]

◆ Efforts to raise immunization rates include collaboration with WIC sites, health centers, free immunization walk-in clinics, and the development of KIDS NET, which includes a statewide immunization tracking system to remind parents and health care providers that inoculations are due.[6]

References

[1] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[2] *National Immunization Survey* (1997). Atlanta: Centers for Disease Control and Prevention.

[3] National Center for Health Statistics (1998). *Health, United States, 1998 With Socioeconomic Status and Health Chartbook*. Hyattsville, MD: US Department of Health and Human Services.

[4-6] Rhode Island Department of Health, Immunization Program, 1997.

Children's Mental Health

◆ Many children are affected by mental health problems. Studies show that at any given time, at least 1 in 5 children and adolescents may have a mental health problem. In addition, 1 in 20 children may have a serious emotional disturbance.[1]

◆ Mental health professionals emphasize early intervention in order to keep children's emotional problems from intensifying. Children with mental health problems are found in all areas of children's services, including education, health, child welfare, and juvenile justice. Multi-agency planning for coordinated care is critical. The Rhode Island Child and Adolescent Services System Program (CASSP) promotes local systems of care that are family-focused, multi-disciplinary, and tailor individual support services to meet the needs of the child and family.

◆ Rhode Island's eight Community Mental Health Centers provided services to a total of 7,865 children and youth during the 1998 fiscal year.[2] Bradley Hospital, Rhode Island's largest psychiatric center for children and adolescents, admitted 1,091 children and youth to its hospital programs for the treatment of emotional disorders in fiscal year 1998.[3] Butler Hospital admitted 804 children and youth, 40% of whom were diagnosed with depressive disorder. In 1998 Butler provided services to an additional 897 children and youth in its outpatient and partial hospital programs.[4]

◆ RIte Care, Rhode Island's Medicaid managed care program, includes coverage for some mental health services. There are significant numbers of children who do not qualify for RIte Care, or who qualify but are not enrolled, whose families are unable to pay for mental health services in the private market.

References

[1] *Children's and Adolescents' Mental Health* (May 1996). [Fact Sheet]. Washington DC: U.S. Department of Health and Human Services.

[2] Rhode Island Community Mental Health Centers, 1998.

[3] Bradley Hospital, June 1997 through July 1998.

[4] Butler Hospital, June 1997 through July 1998.

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Safety

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Cuernavaca

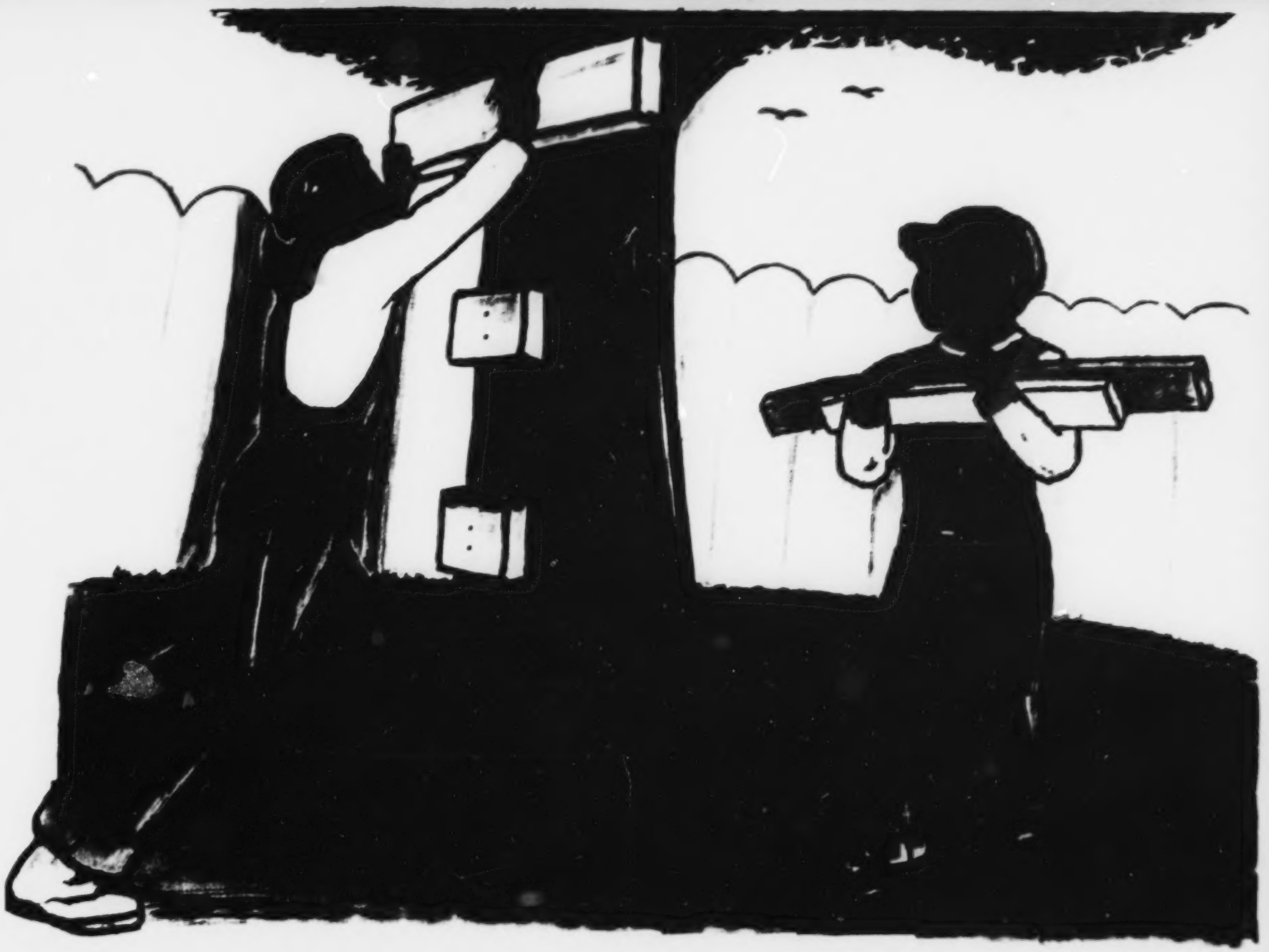
Hay un rumor interno que se desata,
el aire es cántico de plumas,
balbuceo de la hierba.
Hay un cielo azul casi olvidado,
el susurrar de la vida y una plegaria,
hay un ansia infantil de ser amada.

—Aline Pettersson

There's a deep murmur unravelled,
the air is a song of feather,
a soft babble of grass.
There's a memory of heaven revived,
hum of life and a plea.
There's this need, like a baby's, to be loved.

Translated by Judith Infante

201



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Child Deaths

DEFINITION

Child deaths are the number of deaths from all causes to children ages 1 to 14, per 100,000 children. The data are reported by place of residence, not place of death.

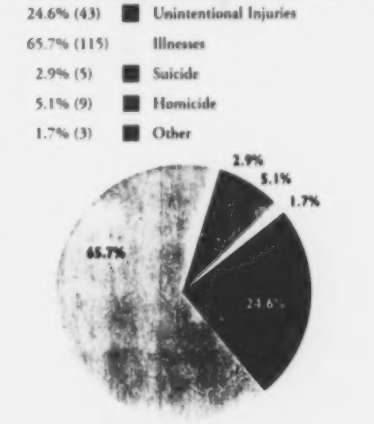
SIGNIFICANCE

The child death rate is a reflection of the physical health of children, the dangers to which children are exposed at home and in the community, and the level of adult supervision children receive.[1] The leading cause of death among Rhode Island children is illness. Of the 175 child deaths in Rhode Island between 1993 and 1997, two-thirds were due to illness, and one quarter were due to unintentional injuries.[2]

It is estimated that 90% of unintentional injuries can be prevented.[3] Unintentional injuries disproportionately affect poor children, young children, males, and minorities. Poverty is the prime predictor of injury. Related factors that may increase a child's risk of injury include, lack of education, young maternal age, multiple siblings, dilapidated housing, and unsafe play areas. The vast majority of unintentional injury-related deaths among children occur in the evening hours when children are most likely to be out of school and unsupervised.[4] Unintentional injuries are the second leading cause of death for Rhode Island children from age 1 to age 14 and the leading cause of death nationally.[5]

Nationally, in 1995, the child death rate for children ages 1 to 14 was 28.0.[6] The Rhode Island child death rate from all causes dropped from 23.1 deaths per 100,000 children in 1983 to 19.6 deaths in 1995.[7]

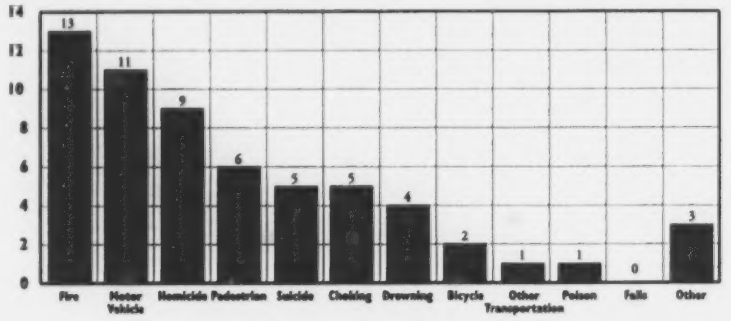
Child Deaths by All Causes, Children Ages 1 to 14, Rhode Island, 1993-1997



n=175

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997.

Cause of Injury Deaths, Children Ages 1 to 14, Rhode Island, 1993-1997



Cause of Injury (n=60)

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997. Data for 1996 and 1997 are provisioned.

Childhood Injury

◆ Between 1993 and 1997 there were 60 deaths due to injury among children ages 1 to 14.[8] Of the 728 hospitalizations due to injury in Rhode Island in 1997, nearly 75% were children ages 1 to 14.[9]

◆ For every childhood death caused by injury, there are approximately 100 non-fatal injuries that result in emergency department visits, many more visits to private physicians and school nurses, and an even larger number of injuries treated at home.[10]

◆ Nationally, 20-25% of all children sustain an injury severe enough to require medical attention, missed school, and/or bed rest.[11] Many of the injuries that do not result in death leave children temporarily or permanently disabled, result in time lost from school, and decrease the child's ability to participate in everyday activities.[12]

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Table 17.

Child Deaths, Rhode Island, 1993-1997

CITY/TOWN	NUMBER OF CHILDREN AGES 1-14	NUMBER OF CHILD DEATHS	RATE PER 100,000
Barrington	15,695	1	NA
Bristol	17,025	3	NA
Burrillville	17,930	3	NA
Central Falls	19,300	2	NA
Charlestown	6,455	0	NA
Coventry	30,045	4	NA
Cranston	57,505	4	NA
Cumberland	25,320	1	NA
East Greenwich	11,450	0	NA
East Providence	42,160	12	NA
Exeter	6,045	1	NA
Foster	4,745	2	NA
Glocester	10,145	1	NA
Hopkinton	7,445	1	NA
Jamestown	4,485	1	NA
Johnston	20,835	5	NA
Lincoln	15,265	2	NA
Little Compton	2,930	0	NA
Middletown	19,030	3	NA
Narragansett	11,390	3	NA
Newport	22,730	1	NA
New Shoreham	675	0	NA
North Kingstown	24,270	8	NA
North Providence	21,615	5	NA
North Smithfield	8,920	1	NA
Pawtucket	65,495	13	NA
Portsmouth	16,315	3	NA
Providence	151,095	44	NA
Richmond	6,345	4	NA
Scituate	9,390	1	NA
Smithfield	15,515	0	NA
South Kingstown	19,180	1	NA
Tiverton	12,140	2	NA
Warren	9,610	3	NA
Warwick	71,880	15	NA
Westerly	20,030	6	NA
West Greenwich	3,635	0	NA
West Warwick	25,840	5	NA
Woonsocket	42,310	14	NA
Core Cities	*300,930*	*74*	*24.6*
Remainder of State	*591,260*	*101*	*17.1*
Rhode Island	*892,190*	*175*	*19.6*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls. Data for 1996 and 1997 are provisional.

NA: Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of children ages 1 to 14 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1993-1997.

References for Indicator

[i] *A Data Book of Child and Adolescent Injury* (1991). Washington, DC: Children's Safety Network.

[ii] Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997.

[iii] National Safe Kids Campaign (1997). *Childhood Injury Fact Sheet*. Washington, DC: National Safe Kids Campaign.

[iv] National Center for Health Statistics (1998). *Health, United States, 1998 With Socioeconomic Status and Health Chartbook*. Hyattsville, MD: US Department of Health and Human Services.

[v] *Kids Count Data Book: State Profiles of Child Well-Being 1998* (1998). Bethesda, MD: The Annie E. Casey Foundation.

[vi] Rhode Island Department of Health, Maternal and Child Health Database, 1991-1995 and 1993-1997.

[vii] Rhode Island Department of Health Hospital Discharge Database, 1998.

[viii] [ix] *Unintentional Injury Factsheet* (1997). Washington, DC: National Center for Injury Prevention and Control.

[x] Lewit, Eugene M. and Linda Schuurman Baker, "Unintentional Injuries" in *The Future of Children*, Vol. 5, Number 1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

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Teen Deaths

DEFINITION

Teen deaths are the number of deaths from all causes to teens ages 15 to 19, per 100,000 teens. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The transition to adulthood confronts teens of all ages with health and safety risks. Teens are more likely than any other age group to take risks that can cause injury to themselves or others. Factors contributing to teen deaths include risk-taking behavior, the use of alcohol and drugs, and violence.[1]

One-third of the deaths among Rhode Island teens are due to intentional injuries (i.e. suicide or homicide). Suicide and homicide claimed the lives of 42 teens between 1993 and 1997.[2] According to the RI Department of Health's 1997 Rhode Island Youth Risk Behavior Survey, 17% of Rhode Island students in grades nine to twelve had made a specific plan to attempt suicide during the 12 months preceding the survey. Thirty-five percent of students had been in a physical fight during the 12 months preceding the survey.[3]

One-third of Rhode Island teen deaths are due to unintentional injuries. Of the 50 teen deaths due to unintentional injuries between 1993 and 1997, almost two-thirds were due to motor vehicle collisions.[4] The 1997 Youth Risk Behavior Survey found that – during the thirty days preceding the survey – only 24% of the teens had always used safety-belts when riding in a car; 36% had driven with someone who had been drinking alcohol; and 33% of 12th graders had driven a car when they had been drinking alcohol.[5] Nationally, motor vehicle accidents are the leading cause of death for young people ages 15 to 20 years old.[6]

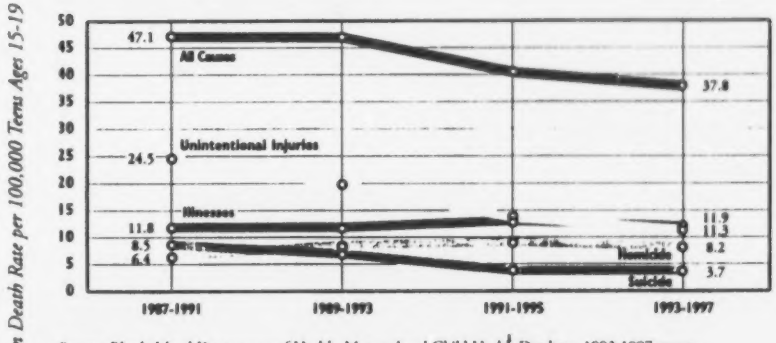
Gun Deaths Teens* Ages 15 to 19, Rhode Island, 1990-1997

YEAR	NUMBER OF DEATHS
1990	4
1991	9
1992	3
1993	8
1994	5
1995	6
1996	3
1997	4

**There were 6 gun deaths to children ages 5 to 14 during this time period.*

Source: National Center for Health Statistics, Vital Statistics (1998). *Rhode Island Mortality Statistics, 1989-1994.* Atlanta, GA: Centers for Disease Control, and Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997.

Teen Deaths by Cause, Teens Ages 15-19, Rhode Island, 1987-1997



Source: Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997 average, 1987-1991 average, 1989-1993 average, 1991-1995 average, and 1993-1997 average. Data for 1996 and 1997 are provisional.

◆ In Rhode Island, the teen death rate from all causes has dropped from 47.1 deaths per 100,000 teens in 1987-1991 to 37.8 deaths per 100,000 teens in 1993-1997. There were 182 teen deaths between 1987 and 1991 compared to 134 teen deaths between 1993 and 1997.[7]

◆ The 1996 national teen death rate of 78.6 was nearly twice that of Rhode Island.[8]

◆ Between 1993 and 1997, the leading causes of death for Rhode Island teens ages 15 to 19 were illnesses (42 deaths), homicide (29 deaths), motor vehicle accidents (32 deaths), and suicide (13 deaths).[9]

Gun-Related Hospitalizations, Rhode Island, 1993-1997

◆ In Rhode Island from 1993 to 1997, 110 children were hospitalized with gunshot wounds. Of these, 3 of the victims were younger than age five, 2 were between the age of 5 and 9, thirteen were between the ages of 10 and 14, and ninety-two were between the ages of 15 and 19. Fifty-two were intentional injuries, 45 were unintentional injuries, and 13 were of undetermined intention.[10]

◆ Between 1993 and 1997, more than half (68%) of the 110 gun-related hospitalizations were Providence residents. From 1996 to 1997, Providence gun-related injuries decreased 71% from 28 hospitalizations to 8 hospitalizations.[11]

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Table 18.

Teen Deaths, Rhode Island, 1993-1997

CITY/TOWN	NUMBER OF TEENS AGES 15-19	NUMBER OF TEEN DEATHS	RATE * PER 100,000
Barrington	5,020	0	NA
Bristol	9,705	2	NA
Burrillville	5,660	3	NA
Central Falls	5,740	1	NA
Charlestown	1,640	1	NA
Coventry	10,695	5	NA
Cranston	21,325	10	NA
Cumberland	9,070	3	NA
East Greenwich	4,040	6	NA
East Providence	14,630	3	NA
Exeter	1,750	1	NA
Foster	1,445	1	NA
Glocester	3,535	3	NA
Hopkinton	2,290	0	NA
Jamestown	1,420	0	NA
Johnston	7,660	2	NA
Lincoln	5,540	2	NA
Little Compton	1,010	1	NA
Middletown	5,650	0	NA
Narragansett	3,910	4	NA
Newport	11,140	4	NA
New Shoreham	125	0	NA
North Kingstown	7,970	2	NA
North Providence	8,705	3	NA
North Smithfield	3,610	1	NA
Pawtucket	22,435	6	NA
Portsmouth	5,310	2	NA
Providence	72,915	39	NA
Richmond	1,815	2	NA
Scituate	3,430	0	NA
Smithfield	9,240	1	NA
South Kingstown	20,300	2	NA
Tiverton	5,020	1	NA
Warren	3,120	3	NA
Warwick	26,290	8	NA
Westerly	6,150	5	NA
West Greenwich	1,295	0	NA
West Warwick	8,990	4	NA
Woonsocket	14,710	3	NA
Core Cities	*126,940*	*53*	*41.8*
Remainder of State	*227,365*	*81*	*35.6*
Rhode Island	*354,305*	*134*	*37.8*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls. Data for 1996 and 1997 are provisional.

Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of teens ages 15 to 19 according to the 1990 Census of Population, multiplied by five to calculate a rate over five years, 1993-1997.

References for Indicator

[1] *Losing Generations: Adolescents in High Risk Settings* (1993). Washington, DC: National Academy Press.

[2, 3] Rhode Island Department of Health, Maternal and Child Health Database, 1993-1997.

[4, 5] 1997 *Rhode Island Youth Risk Behavior Survey* (1998). Providence, RI: Rhode Island Department of Health.

[6] U.S. Department of Transportation (1996). *Traffic Safety Facts 1996.* Washington, DC: National Highway Traffic Safety Administration.

[7] *National Vital Statistics Report* (1998). Vol. 47, No. 9, November 10, 1998. Atlanta, GA: Centers for Disease Control and Prevention.

[8, 9] Rhode Island Department of Health Hospital Discharge Database, 1993-1997.

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Homeless Children

DEFINITION

Homeless children is the number of Rhode Island children under 13 years old who received emergency housing services at emergency homeless shelters and domestic violence shelters between July 1, 1997 and June 30, 1998.

SIGNIFICANCE

Homelessness severely affects the health and well-being of all family members. Stable housing is a basic necessity if a person is going to be productive at work or school. Transience makes it difficult or impossible to obtain and keep a job. Homeless children often suffer from illness and serious emotional distress, exhibiting short attention spans, withdrawal, aggression, speech delays, and sleep disorders. They are more at risk for lead poisoning, asthma, and malnutrition and are at greater risk for educational underachievement.[1] Periods of homelessness, or a rapid succession of moves due to an unstable living situation, have a negative impact on a child's education.[2] Children find it difficult to concentrate in school and develop supportive relationships with adults or peers when their lives are disrupted by temporary moves.

Poverty and lack of affordable housing are factors in family homelessness.[3] The shortage of affordable apartments and the dwindling number of housing subsidies have caused many Rhode Island families to "double-up", resulting in overcrowded, unstable living conditions. With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[4]

Domestic violence contributes to homelessness among families.[5] Exposure to domestic violence can limit children's cognitive development and their ability to form close attachments.[6] Children in violent homes fear for their mother's safety and their own, and often experience anxiety, fear, sleep disruption, and school problems.[7]

In Rhode Island in 1998, there were a total of 722 children under age 13 that received shelter from the emergency and domestic violence shelter system. Of these, 387 children were age 4 or under and 335 children were ages 5 to 12. Children under age 13 years old represented 20% of the population receiving shelter at emergency and domestic violence shelters in 1998.

Children Under Age 13, Using Emergency and Domestic Violence Shelters, Rhode Island, 1994-1998

◆ Between 1994 and 1998, the number of children under age 13 that received shelter at emergency shelters and domestic violence shelters decreased from 1,473 children between July 1, 1993 and June 30, 1994 to 722 children between July 1, 1997 and June 30, 1998.

◆ These numbers do not include families who were turned away from shelters or those who sought shelter with family members or friends. Homelessness frequently separates children from their families due to shelter policies that may not allow older boys and fathers to stay in the shelter and parents deciding to have children stay with friends or relatives.

◆ 35% of families with children in the Rhode Island shelter system had been "doubled-up" with family members or friends just before moving to the shelter. Twelve percent had most recently been at another shelter.

◆ More than one-half (58%) of the families seeking shelter had incomes below $10,000 annually and almost one-quarter (23%) had no source of income at all.

◆ Families reported needing shelter for the following reasons: 37% domestic violence; 14% legal eviction; 10% other housing problems including housing costs, landlord/tenant disputes, utilities shut-off; 11% relocation from outside Rhode Island; 6% family separation; 5% no income; and 17% unspecified reasons.

Source: *Rhode Island Emergency Shelter Information Project Annual Report, July 1, 1997 - June 30, 1998* (1999). Providence, RI: The Rhode Island Emergency Food and Shelter Board.

116

117

DEFINITION

Homeless youth is the number of Rhode Island youth ages 13 to 21 who are homeless or at risk of homelessness, have run away from home, or have been thrown out of their home and not allowed to return.

SIGNIFICANCE

Many homeless and runaway youth are fleeing disruptive and abusive family conditions.[1] Some runaway youth are considered to be "throw-aways" who were told to leave a household, were abandoned or deserted, or tried to return home and were denied access.[10] Homeless youth are at risk of being physically and/or sexually victimized, abusing drugs and alcohol, attempting suicide, becoming victims or perpetrators of crime, receiving money for sex to meet their basic survival needs, and contracting HIV/AIDS.[11]

Adolescents who have supportive relationships with their parents, their families, other caring adults, and their school community are healthier and less likely to be involved in high-risk situations than those who lack such supportive relationships. This "connectedness" is a protective factor in the lives of teens regardless of their race, ethnicity, family structure, or poverty status.[12]

Homeless/Runaway/Throwaway Youth in Rhode Island

Emergency Shelter System

◆ There were 64 youth between the ages of 13 and 17 who received shelter through the emergency shelter system in Rhode Island between July 1997 and June 1998.[13] This is an underestimate of the number of youth in need of shelter, as many of the emergency and domestic violence shelters do not accept males over the age of twelve.

Travelers Aid

◆ While there are no accurate data on the total number of homeless and runaway youth in Rhode Island, there has been a steady increase in the number of homeless youth served by Travelers Aid.[14] Rhode Island does not have an overnight emergency shelter for runaway youth.

◆ A total of 1,006 youth under age 18 accessed services through Travelers Aid from January through December 1998. Of these, 252 were homeless, 314 were runaways/throwaways, and 287 were in transitional arrangements, including treatment centers, shelters, or "doubled up" with family members. The remainder were considered to be at-risk for homelessness.[15]

◆ Of the youth that received services in 1998 from Travelers Aid, almost half had dropped out of school; the majority had incomes below the poverty line; one third were uninsured; and 12% of the youth had children themselves.[16]

◆ In 1998, the Travelers Aid Runaway Youth Project provided street outreach services in Providence, Pawtucket, Central Falls and Newport to 5,267 youth at-risk for homelessness or who were homeless/runaways.[17]

DCYF Night-to-Night Placements and Unauthorized Absence

◆ In 1998, an average of 76 youth per month were in "night-to-night placements." Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting a permanent foster care placement, a group home/treatment placement, or who have run away from their current placement.[18]

◆ As of December 1998, 116 youth in DCYF care were classified as unauthorized absence/runaways.[19]

References for Indicators

Homeless Children

[1] *America's Children At Risk: A National Agenda for Legal Action* (1993). Chicago, IL: American Bar Association.

[2] *Children and Their Housing Needs: A Report to KIDS COUNT* (1993). Washington, DC: Center on Budget and Policy Priorities.

[3] National Coalition for the Homeless (1997). "Homeless Families With Children" NCH Fact Sheet #7 (October 1997). Washington, DC: National Coalition for the Homeless.

[4] *The Impact of Domestic Violence on Children: A Report to the President of the American Bar Association* (1994). Chicago: American Bar Association Center on Children and the Law.

[5] *Children in Violent Homes (1994).* "Courts and Communities: Confronting Violence in the Family," State Justice Institute Conference. San Francisco, CA.

[6] Rhode Island Emergency Shelter Information Project, July 1, 1997-June 30, 1998 (1999). Providence, RI: RI Emergency Food and Shelter Board.

Homeless Youth

[7] [11] *Youth with Runaway, Throwaway, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors* (1995). FYSB Update. Washington, D.C.: Family and Youth Service Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

[8] Schneider, D. (1995). *American Childhood: Risks and Realities.* New Jersey: Rutgers University Press.

[9] Blum, R.W., & Rinehart, P.M. (1997). *Reducing the Risk: Connections that Make a Difference in the Lives of Youth.* Minneapolis, MN: University of Minnesota, Division of General Pediatrics and Adolescent Health.

[10] Rhode Island Emergency Shelter Information Project, July 1, 1997-June 30, 1998 (1999). Providence, RI: The Rhode Island Emergency Food and Shelter Board.

[12] [13] [14] [15] [16] [17] Travelers Aid, Providence, RI. Year-End Reports, 1995, 1996, 1997, 1998.

[18] Rhode Island Department of Children, Youth and Families, December 1998.

[19] Rhode Island Office of the Child Advocate, December 1998.

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Juveniles Referred to Family Court

DEFINITION

Juveniles referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for all wayward and delinquent offenses.

SIGNIFICANCE

Poor school performance, including chronic truancy and falling behind one or more grade levels, increases the likelihood of involvement with the juvenile justice system. Other risk factors for juvenile crime and delinquency include poverty, family violence, inadequate supervision, limited education and job skills, substance abuse, and mental health problems.[1,2,3] Most juvenile crime takes place in the after-school and early evening hours.[4]

Prevention and early intervention are the most cost-effective approaches to reducing delinquency.[5] The best prevention for most adolescent risk behaviors (including crime and substance abuse) enables youth to develop caring, supportive relationships within their families, schools, peer groups, and community. Well-designed programs can reduce truancy, provide support to parents, build mentoring relationships with adults, and help students learn how to problem-solve and resolve conflict peacefully. Success in school and in life can be promoted with after-school tutoring, vocational training, recreation, community service, and leadership development. Programs are most effective when they are comprehensive, community-based, culturally-appropriate and initiated early in a child's development.[6]

The Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, except for truancy cases which are referred by local school departments. Approximately one-third of all cases referred to Family Court are diverted instead of proceeding to a formal court hearing. Juvenile diversion options include community service, restitution, mental health or substance abuse counseling, and/or a community-based program. According to Rhode Island Family Court, community-based diversion programs, rehabilitation options, and community-based placements are not available to all youth who need them.

Between 1988 and 1998, the percentage of Rhode Island youths ages 10 to 17 who were referred to Family Court increased from 3.4% to 4.9%. These numbers do not include instances in which local law enforcement agencies refer a juvenile to a youth diversionary program or a city or town juvenile hearing board.[7]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, by Type of Offense, Rhode Island, 1998

35%	Property Offenses	5%	Violent Crime Offenses
14%	Status Offenses*	4%	Traffic Offenses
12%	Simple Assaults	3%	Weapons Offenses
12%	Disorderly Conduct	5%	Other**
10%	Drugs and Alcohol		

n = 9,272

**Status Offenses are age-related acts that would not be punishable if the offender were an adult, such as truancy and disobedient conduct.*

***Other includes offenses such as false fire alarms, conspiracy, aiding and abetting, crank/obscene phone calls, and sex offenses other than rape.*

◆ In 1998, there were 4,700 juveniles referred to Family Court for 9,272 offenses. Since 1994, the number of juveniles referred to Family Court has increased by 10% (4,280 juveniles in 1994 versus 4,700 in 1998) while the number of offenses has decreased by 5% (9,766 offenses in 1994 versus 9,272 in 1998).

Source: Rhode Island Family Court, RIJISS Intake Statistics, Year End Reports, 1994 and 1998

Comprehensive Strategy for the Juvenile Justice System

◆ Rhode Island is one of six initial states participating in the implementation of the U.S. Justice Department Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Comprehensive Strategy for Serious, Violent and Chronic Juvenile Offenders.

◆ The OJJDP Comprehensive Strategy involves a broadbase of community members in Providence, Pawtucket, Woonsocket, Newport, and Central Falls in creating and implementing a set of strategic actions designed to :

Improve the effectiveness of the juvenile justice system;
Provide appropriate prevention methods to children, families, and communities; and,
Intervene in the lives of first-time offenders with structured programs and services.[8]

◆ Effective prevention strategies combine programs such as truancy reduction, substance abuse services, youth mental health services, mentoring, conflict resolution, after-school tutoring, vocational training, recreation, community service and leadership development.[9,10]

Juvenile Violent Crime Decreases in Rhode Island

◆ Throughout the 1990s, violent crime offenses have accounted for less than 6% of all offenses for youth ages 10 to 17. Over the past year, juvenile violent crime offenses have decreased 24%, from 613 violent crime offenses in 1997 to 464 violent crime offenses in 1998, the lowest number of violent offenses since 1991.[11]

◆ The core cities of Providence, Pawtucket, Woonsocket, Newport and Central Falls accounted for 55% of all juvenile violent crime in 1998 and for 45% of all juveniles referred for any offense. The juvenile crime rate, including the rate for violent crimes, decreased in the core cities between 1997 and 1998.[12]

◆ Research has shown that the social context in which people live can promote violence. Factors such as poverty, unemployment, discrimination, exposure to violence, access to firearms, gang involvement, and alcohol and drug use are major determinants of youth violence.[13]

◆ Abused and neglected children commit more offenses and are twice as likely to be arrested for a violent crime. Child abuse prevention and intervention are needed to interrupt the cycle of violence and should focus on creating nurturing communities for children before they begin to get into trouble.[14,15]

Juveniles Tried as Adults

◆ In 1998, the Attorney General's Office filed 47 motions for waiver of jurisdiction to try juveniles as adults. 26 of these motions were granted; 2 waivers were converted to disposition; 16 are pending; and three are unknown.[16]

◆ In 1997, the Attorney General's Office filed 48 motions for waiver of jurisdiction to try juveniles as adults. 43 of these motions were granted and 5 waivers were withdrawn.[17]

The Rhode Island Training School for Youth

◆ The Department of Children, Youth, and Families operates the Rhode Island Training School for Youth, the state's 174-bed residential detention facility for adjudicated youths and those awaiting trial.

◆ As of December 1, 1998, there were 205 youths at the Training School, which is 18% over capacity. 1,286 youth passed through the Training School during 1998.[18]

◆ The Training School population ranges in age from 10 to 22; the average age is 16.5 years; 85% of the residents are male. 54% of the youth at the Training School are ethnic or racial minorities.[19]

◆ The mean reading level of the total Training School population is fifth grade; and the mean mathematics level is fifth grade. A survey of educational records of Training School youth confirms significant academic difficulty. Based on 75 records reviewed, only 17 youth were attending school one year prior to detention/adjudication and had passing grades.[20]

References for Indicator

[1] *Juvenile Offenders and Victims, A National Report* (1995). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice.

[2] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

[3,4] Bilchik, S. (July 1998). *OJJDP Fact Sheet #82.* "Mental Health Disorders and Substance Abuse Problems Among Juveniles." Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[5] Chaiken, M.R. (June 1998) *Issues and Practices in Criminal Justice: Kids, COPS, and Communities.* Washington, DC: U.S. Department of Justice, National Institute of Justice and The Carnegie Corporation of New York.

[6] *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1995). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice.

[6,7,8] *Combating Violence and Delinquency: The National Juvenile Justice Action Plan* (1996). Washington, DC: Coordinating Council on Juvenile Justice and Delinquency Prevention.

[9,10,11] Rhode Island Family Court, RIJISS Intake Statistics, Year End Reports, 1988 to 1998.

[13] American Psychological Association (1993). *Violence and Youth: Psychology's Response.* New York: American Psychological Association.

[14] *The Future of Children: The Juvenile Court* (1996). Los Altos, CA: The Center for The Future of Children, The David and Lucille Packard Foundation.

[16,17] Rhode Island Office of the Attorney General, 1997 and 1998.

[18,19,20] Superintendent's Office, RI Training School for Youth, January 1999.

122 BEST COPY AVAILABLE

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total number of indicated cases of child abuse and neglect per 1,000 children. "Indicated case" means that credible evidence exists that child abuse and/or neglect occurred following an investigation of an abuse report. An indicated case can involve more than one child. Child abuse includes physical, sexual, and emotional abuse. Child neglect includes physical, emotional, and medical neglect.

SIGNIFICANCE

Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Children are at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple problems such as inadequate income, lack of a job or a decent place to live, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence.[1] Recent studies confirm that child abuse is linked to increases in dropout rates, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional disturbances, promiscuity, and teenage pregnancy.[2,3,4]

Children can be victims of child maltreatment regardless of their racial or ethnic background or socio-economic status. Families benefit from access to community-based, comprehensive services that are able to flexibly respond to their needs. Resources dedicated to prevention services that assist families before parents abuse their children are extremely limited. Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Preventing child abuse and neglect requires help with housing, food, and child care as well as parenting education and counseling for substance abuse, domestic violence, and other problems.[5,6] Of all neglect allegations in Rhode Island in 1998, almost half (47%) were due to a lack of supervision and 9% were due to inadequate food, shelter, or clothing.[7] Current estimates indicate that between 50% and 80% of families involved with child protective services are dealing with a substance abuse problem.[8]

An increasing number of children entering relative and non-relative foster care homes have significant emotional, behavioral and medical needs, including developmental delays, low birth weight, congenital diseases, and health problems due to prenatal drug exposure. The complex needs of the children require adequate support for foster parents and a comprehensive array of services and supports in the community.[9]

Facts About Child Abuse in Rhode Island

◆ In 1998 in Rhode Island, 3,453 children were determined by DCYF to be victims of abuse and neglect.[10] Parents, relatives, or household members were the perpetrators in 91% of all maltreatment incidents.[11]

◆ 36% of child abuse and neglect victims (based on indicated allegations) were under age 6. There were 610 children under the age of three who were abuse and neglect victims; of these, 235 were infants under the age of one.[12]

◆ In 1997, twenty-four children were hospitalized with the diagnosis of child abuse or neglect.[13]

Child Abuse and Neglect in Rhode Island Communities, 1994-1998

TOWN	RATE OF INDICATED CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN	TOWN	RATE OF INDICATED CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Central Falls	19.9	Newport	12.5
Woonsocket	19.8	Warren	11.7
West Warwick	14.9	Westerly	10.7
Providence	13.9		
Pawtucket	12.9	*Rhode Island*	*9.4*

◆ Between 1994 and 1998, there was a yearly average of 2,628 indicated cases of child abuse and neglect in Rhode Island, a rate of 9.4 per 1,000 children.

◆ Between 1994 and 1998, eight communities had child abuse and neglect rates that exceeded the state rate: Central Falls, Woonsocket, West Warwick, Providence, Pawtucket, Newport, Warren, and Westerly.

◆ These eight communities account for nearly two-thirds of the indicated cases of child abuse and neglect in Rhode Island.

Source: Rhode Island Department of Children, Youth and Families, 1994, 1995, 1996, 1998 average. Data for 1997 are not available on a city/town basis. Calculations by Rhode Island KIDS COUNT.

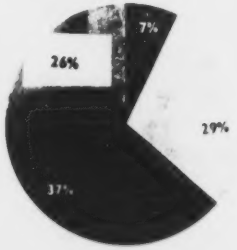
124

125

Indicated Cases of Child Abuse and Neglect, Rhode Island, 1998

By Age of Victim

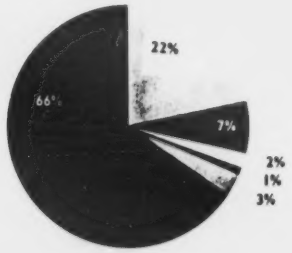
7%	Under Age 1
29%	Ages 1 to 5
37%	Ages 6 to 11
26%	Ages 12 to 18



*(n=3,453)**

By Type of Abuse

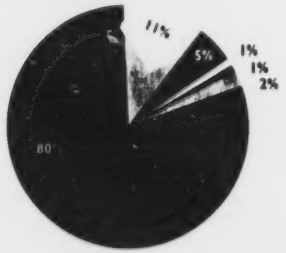
66%	Neglect
22%	Physical Abuse
7%	Sexual Abuse
2%	Medical Neglect
1%	Emotional Abuse
3%	Other



*(n=4,452)***

By Relationship of Victim to Perpetrator

80%	Parents
11%	Relatives/Household Members
5%	Child Care Providers
1%	Foster Parents
1%	Residental Facility Staff
2%	Other or Unknown



*(n=4,402)****

Notes on Pie Charts

All data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 1998. Numbers may not add to 100 due to rounding.

** The number of victims is higher than the number of indicated cases. One indicated case can involve more than one child victim. Data reflect an unduplicated count of child victims.*

***This number reflects maltreatment events, not children. Children often experience more than one type of abuse. For example, if a child were physically and sexually abused, two maltreatment events would be counted.*

****Perpetrators can abuse more than one child and can abuse a child more than once.*

Rhode Island Child Deaths Due to Child Abuse and/or Neglect*

YEAR	NUMBER OF DEATHS	YEAR	NUMBER OF DEATHS
1990	4	1995	5
1991	7	1996	4
1992	4	1997	2
1993	3	1998	3
1994	5	*1990-1998 Total*	*37*

◆ Between 1990 and 1998, thirty-seven children died as a result of injuries due to abuse by a parent or caretaker.

**Based on R.I. Department of Children Youth and Families determination of death due to child abuse or neglect by parent or caretaker.*

Federal Adoption and Safe Families Act of 1997

◆ The Adoption and Safe Families Act of 1997 affects children in the care of the Department of Children Youth and Families and other families in need of support. Provisions in the law shorten the time frame for a child's first permanency hearing; offer states financial incentives for increasing the number of adoptions; and sets new requirements for states to petition for termination of parental rights.[14]

◆ In 1998 in Rhode Island, 396 petitions for termination of parental rights were filed in Rhode Island Family Court.[15] In 1997, the Rhode Island General Assembly passed a law which would allow Family Court to establish a voluntary mediation program for termination of parental rights and child protection matters.

◆ The Adoption and Safe Families Act reauthorizes and expands the Family Preservation and Support Program (renamed "Promoting Safe and Stable Families") — requiring states to provide community-based family support services; family preservation services; family reunification services; and adoption promotion and support services.[16]

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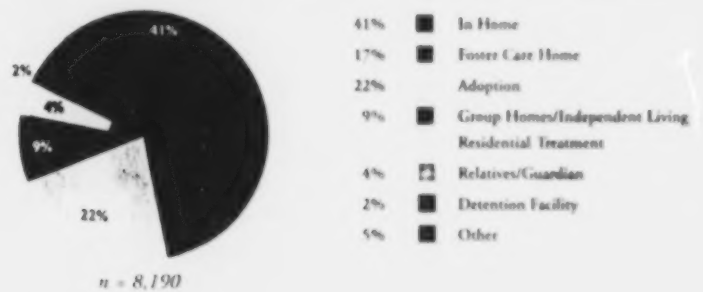
DCYF Caseload:

On December 31, 1998 the total active caseload of the Rhode Island Department of Children, Youth and Families was 8,190 children. This number includes 1,737 children in adoptive homes, whose adoptive parents receive subsidies or other financial support. This does not count the children in pending child abuse and neglect investigations or children enrolled in DCYF community-based programs. This is an increase of 6% since December 1995 when the total active caseload was 7,760 children.[17]

Children in DCYF Care by Living Arrangement



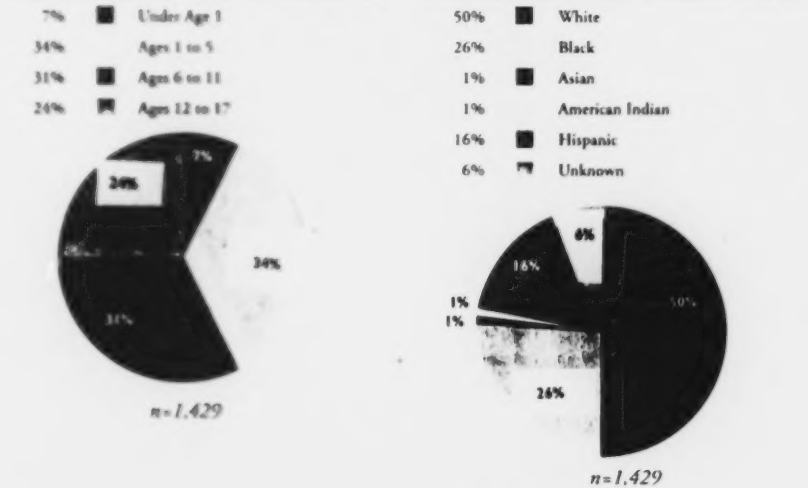
Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 1998.

◆ Out-of-home placements include foster homes (relative, non-relative and specialized), placement with a relative or guardian, group home, shelter care, residential treatment, and medical facilities. As of December 1, 1998, there were 3,330 Rhode Island children under age 21 in the care of DCYF in out-of-home placements. 116 were classified as runaways.[18]

◆ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting foster care placement or a group home/treatment placement or who have run away from their current placement. Between January and December, 1998, there was an average of 76 night-to-night placements per month, with a low of 25 placements in December and a high of 131 placements in May.[19]

Children in Foster Care Homes, Rhode Island, 1999

◆ In Rhode Island as of January 1999, there were 1,429 children in foster care homes, 17% of children under the care of DCYF. There were 518 licensed foster care homes, 434 certified foster care homes, and 148 licenses pending.[20]



Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 1999.

◆ Child abuse and neglect happens to children of all races, in all kinds of communities, in all economic classes. But national data indicate that poor families and families of color are more likely to be identified by the child welfare system and are more likely to have their children removed and placed in foster care; once in foster care, children of color are more likely to remain there for long periods of time, and to experience multiple placements in different homes before they are returned to their parents.[21]

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Table 19.

Number of Indicated Cases of Child Abuse & Neglect per 1,000 Children, Rhode Island 1998

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER AGE 21	NUMBER OF INDICATED CASES OF CHILD ABUSE/NEGLECT	1998 RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	4,487	6	1.3
Bristol	6,186	27	4.4
Burrillville	5,109	20	3.9
Central Falls	5,579	115	20.6
Charlestown	1,783	13	7.3
Coventry	8,880	41	4.6
Cranston	17,558	124	7.1
Cumberland	7,523	41	5.4
East Greenwich	3,346	17	5.1
East Providence	12,520	77	6.2
Exeter	1,710	6	3.5
Foster	1,358	2	1.5
Glocester	2,944	19	6.5
Hopkinton	2,123	10	4.7
Jamestown	1,282	5	3.9
Johnston	6,309	28	4.4
Lincoln	4,543	26	5.7
Little Compton	867	2	2.3
Middletown	5,598	31	5.5
Narragansett	3,757	14	3.7
Newport	7,858	84	10.7
New Shoreham	184	0	0.0
North Kingstown	6,993	49	7.0
North Providence	6,846	54	7.9
North Smithfield	2,724	12	4.4
Pawtucket	19,655	254	12.9
Portsmouth	4,716	16	3.4
Providence	52,674	650	12.3
Richmond	1,766	11	6.2
Scituate	2,809	6	2.1
Smithfield	5,955	11	1.8
South Kingstown	9,612	47	4.9
Tiverton	3,752	15	4.0
Warren	2,851	34	11.9
Warwick	21,596	159	7.4
Westerly	5,771	61	10.6
West Greenwich	1,067	3	2.8
West Warwick	7,818	124	15.9
Woonsocket	12,511	245	19.6
Out of State/Unknown	*NA*	*85*	*NA*
Core Cities	*98,277*	*1,348*	*13.7*
Remainder of State	*182,343*	*1,111*	*6.1*
Rhode Island	*280,620*	*2,459*	*8.8*

Source of Data for Table/Methodology

Data are from the State of RI Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), number of reports (indicated cases) for the period January 1, 1998 to December 31, 1998. Population data are from US Bureau of the Census, 1990 Census of Population.

An indicated case is an investigated report of child abuse and neglect for which credible evidence exists that child abuse and/or neglect occurred. An indicated case can involve more than one child.

The denominator is the number of children under the age of 21 according to the 1990 Census of Population.

References for Indicator

[illegible] American Bar Association (1993). *America's Children at Risk: A National Agenda for Legal Action.* Chicago: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[illegible] "Protecting Children From Abuse and Neglect" in *The Future of Children.* Vol. 8, No. 1 (Spring, 1998). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

* *Hidden Casualties: The Relationship Between Violence and Learning* (1995). Washington, DC: The National Health and Education Consortium.

[illegible] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 1998.

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[illegible] "Summary of The Adoption and Safe Families Act of 1997" (1997). Factsheet: CWLA Interactive. Washington, DC: Child Welfare League of America.

[illegible] Rhode Island Office of the Child Advocate, 1998.

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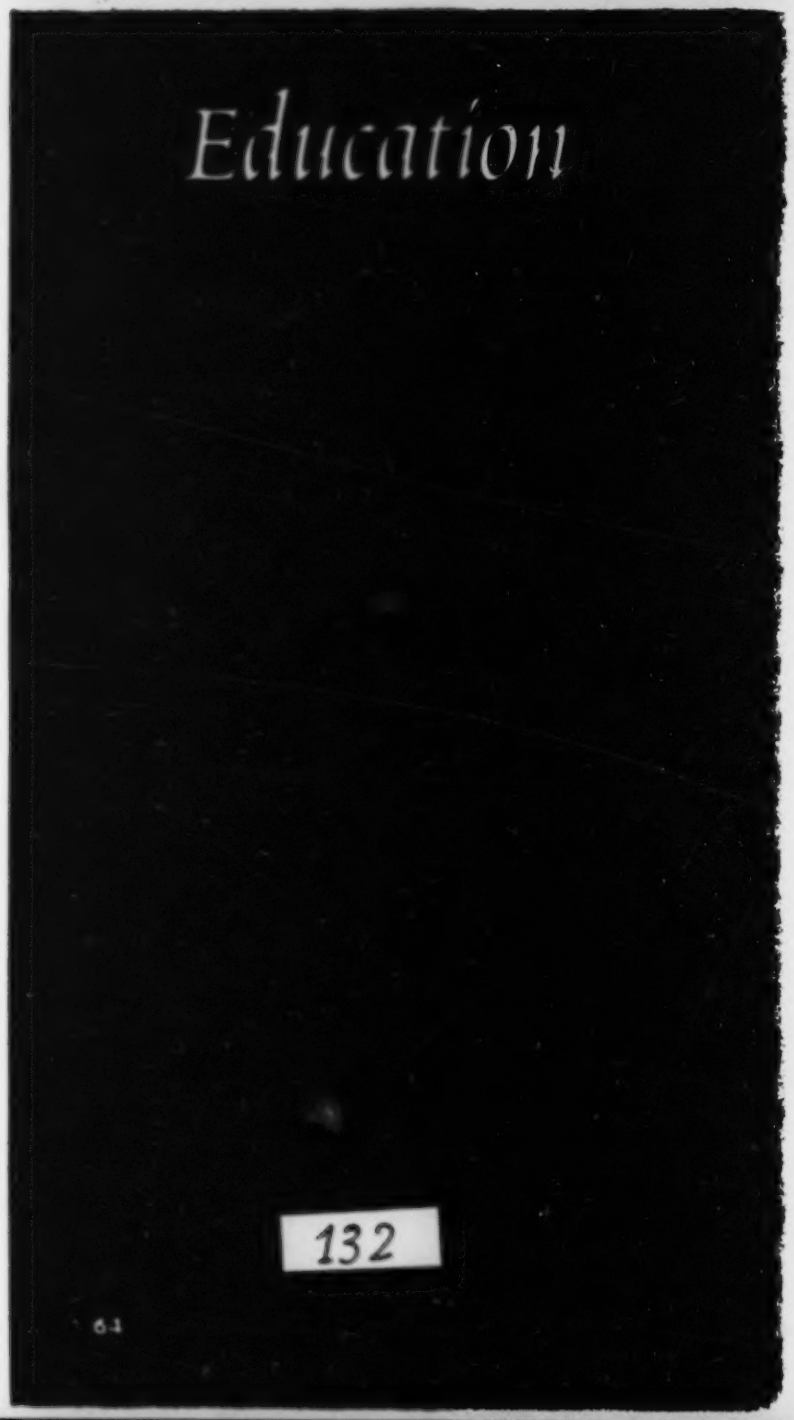


From Ulysses

I am a part of all that I have met;
Yet all experience is an arch where-thro'
Gleams that untràvell'd world, whose margin fades
Forever and forever when I move.

— Alfred, Lord Tennyson

134

135

Infant and Pre-School Child Care

DEFINITION

Infant and pre-school child care is the number of regulated child care slots per 100 children under age 6 in need of regulated child care. Regulated child care slots include full-time licensed child care center slots and certified family child care home slots.

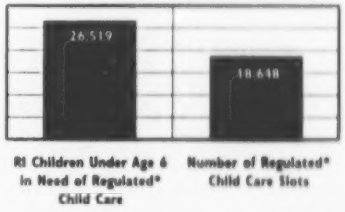
SIGNIFICANCE

Child care has become a fundamental need for Rhode Island families over the past two decades. Well-designed child care programs can promote healthy cognitive, emotional and social development.[1] High quality child care provides a safe and nurturing learning environment for infants and young children. Recent brain research indicates that early care and education has long-lasting effects on how children learn and develop, cope with stress, and handle their emotions.[2] Children who attend Head Start, pre-kindergarten, or other center-based preschool programs have higher emerging literacy skills than children who do not attend.[3]

The quality and stability of child care is critical to a parent's ability to work.[4] In Rhode Island in 1996, 66% of mothers with children under the age of six were in the labor force.[5] More than 45,000 Rhode Island infants and pre-school children are in need of some form of child care because the mother is in the labor force.[6] Nationally, 47% of all employed mothers use either center-based child care or family child care homes for their young children.[7] Recent changes in welfare laws linking cash assistance to work or participation in work-readiness programs will mean additional children in need of quality child care.

In Rhode Island, there are an estimated 70 regulated child care slots for every 100 children under age six in need of a licensed child care center or certified family child care home.[8] The supply of licensed and certified child care is especially limited in low-income communities and rural areas, for infants and children under age 3, for children with disabilities and special health care needs, and for parents with unconventional or shifting work hours.[9,10]

Licensed and Certified Child Care for Children Under Age 6, Rhode Island, 1998



**Includes licensed child care centers and certified family child care homes.*

Source: Calculations by Rhode Island KIDS COUNT based on data from the Rhode Island Department of Human Services, the U.S. Bureau of the Census, and Options for Working Parents. See page 84 for methodology.

Quality Child Care is Linked to...

Wages and Benefits

◆ Annual turnover for child care providers is nearly three times the rate reported for U.S. companies as a whole and nearly five times the rate reported for public school teachers.[11]

◆ Experienced child care providers frequently leave their jobs because of low salaries and inadequate benefits. Child care providers are among the lowest paid workers in the labor market.[12]

Licensing

◆ The safety and healthy development of children require quality standards for the licensing and regulation of child care providers, including family child care homes.[13]

◆ Licensing standards focus on maintaining children's health and safety, setting staff-child ratios and group sizes that support child development, and setting minimum staff training requirements.

Accreditation

◆ The National Association for the Education of Young Children accreditation standards are based on research showing that children benefit emotionally, socially, and cognitively when centers demonstrate: developmentally-appropriate curriculum; low staff-to-child ratios; small group sizes; higher levels of staff education and training; low staff turnover; and higher levels of staff compensation.[14]

Professional Development

◆ A staff with more formal education and specialized early childhood training provides better quality services for children and families.[15]

◆ Professional training is most effective when providers learn about child and family development, management, and child care policies; gain credentials that are linked to compensation or transfer to other career pathways; and form networks of support, engage in continuous learning from their peers and become mentors to others.[16]

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Rhode Island's Child Care Subsidy System

Eligible Families

◆ Rhode Island working families with incomes up to 200% of poverty are eligible for a child care subsidy for their children up to age 14. This will increase to 225% of poverty on July 1, 1999 and to 250% of poverty on July 1, 2000.

◆ Families receiving subsidies may have a co-payment based on family income. Families participating in the Rhode Island Family Independence Program who are working or enrolled in education, training or work-related activities are eligible for child care at no cost to the family.

Provider Rates and Benefits

◆ Reimbursement rates for licensed child care centers and certified family child care providers paid by DHS will be incrementally increased to the 75th percentile of weekly market rates by the year 2000 (based on a new market rate survey).

◆ Rhode Island offers paid health insurance to certified family child care home providers and center-based providers that care for children who receive state child care subsidies. These providers can enroll in RIte Care, the state's managed health care program. Rhode Island is one of the only states offering health insurance to child care providers.

Child Care Supply Inadequate to Meet Demand

◆ More than 80% of Rhode Island families receiving child care subsidies choose licensed child care centers or certified family child care homes for their child care arrangements.[17]

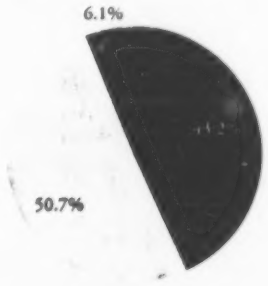
◆ Even as more child care subsidies become available, there is a structural shortage of child care centers and certified family child care homes necessary to meet demand.[18]

◆ The supply of licensed and certified child care is especially limited in low-income communities and rural areas, for infants and children under age 3, for children with disabilities and special health care needs, and for parents with unconventional or shifting work hours.[19]

Child Care Subsidies, Rhode Island, December 1998

By Family Income

43.2%	■	Cash Assistance (FIP)
50.7%		Low-Income Working Families
6.1%	■	Other (DCYF, JTPA)

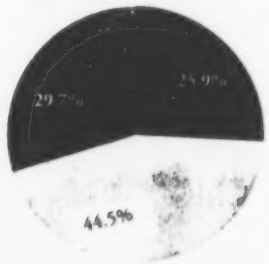


By Provider Type

7.2%	■	In-Home
67.5%		Licensed Centers
13.2%	■	Family Child Care Homes
12.1%	■	Relative

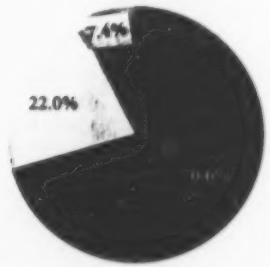
By Age of Child

25.9%	■	Infant
44.5%		Pre-School
29.7%	■	School Age



By Hours in Care

70.6%	■	Full-Time (≥ 20 hours)
22.0%		Half-Time (10-19 hours)
7.4%	■	Less than Half-Time (<10 hours)



Total Number of Subsidies is 8,747 as of December 1998.

Source: Rhode Island Department of Human Services, December 1998.

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Child Care

Insufficient Supply of Child Care and Head Start

◆ As of December 1, 1998 there were 12,172 children ages 1 to 5 in families receiving cash benefits through the Family Independence Plan (FIP).[20]

◆ Table 20 shows the significant shortage of child care center slots, family child care home slots, and Head Start slots to meet demand. Many low-income families are unable to access a large proportion of these slots, due to a combination of factors including insufficient income to pay higher fees, lack of transportation, and/or reliance on subsidies which do not meet the cost of providing the service.[21]

◆ The core cities of Providence, Pawtucket, Woonsocket, Newport and Central Falls, have only enough capacity to enroll 36% of 3 and 4 year olds eligible for Head Start. In Central Falls and Pawtucket less than 15% of eligible children are enrolled.[22]

◆ Table 21 shows that Rhode Island has 70 child care slots for every 100 children in need of a child care slot. For every 100 children in need of regulated child care: Central Falls has 21 slots; Pawtucket has 42 slots; Woonsocket has 43 slots; Newport has 52 slots; and Providence has 76 slots.

Children Under Age 6 in Family Independence Program (FIP), RI, 1998 and Number of Licensed Child Care and Head Start Slots for Children Under Age 6, RI, 1998

Table 20.

	INFANT/TODDLERS			PRESCHOOLERS		
CITY/TOWN	# 1 & 2 YEAR OLDS ENROLLED IN FIP	# CHILD CARE CENTER SLOTS < AGE 3	# CERTIFIED FAMILY CHILD CARE HOME SLOTS*	# 3 TO 5 YEAR OLDS ENROLLED IN FIP	HEAD START SLOTS AGES 3 TO 5	# CHILD CARE CENTER SLOTS AGES 3 TO 5
Barrington	3	91	57	8	3	211
Bristol	38	49	76	42	28	104
Burrillville	20	0	54	40	42	69
Central Falls	288	0	60	376	40	90
Charlestown	8	14	21	18	4	12
Coventry	53	32	199	72	41	141
Cranston	212	270	410	305	194	723
Cumberland	35	42	185	44	18	61
East Greenwich	14	191	28	17	1	374
East Providence	146	196	173	216	93	577
Exeter	8	15	6	8	1	47
Foster	7	23	5	5	0	42
Glocester	11	16	42	16	10	20
Hopkinton	9	0	35	26	11	0
Jamestown	1	31	21	7	1	33
Johnston	62	62	116	112	39	284
Lincoln	28	90	88	47	18	222
Little Compton	2	0	0	1	5	0
Middletown	21	140	16	42	37	370
Narragansett	31	32	40	42	18	108
Newport	169	82	37	257	136	228
New Shoreham	1	0	0	2	0	0
North Kingstown	56	113	111	79	44	361
North Providence	105	60	129	133	41	158
North Smithfield	6	0	67	10	3	0
Pawtucket	524	176	400	818	60	464
Portsmouth	15	63	31	17	11	98
Providence	2,154	773	1,373	3,245	918	2,151
Richmond	9	3	41	15	3	40
Scituate	4	47	14	13	1	81
Smithfield	16	117	52	12	4	268
South Kingstown	34	130	78	34	24	267
Tiverton	17	25	56	24	29	145
Warren	23	10	39	37	23	96
Warwick	165	440	326	266	138	1,233
Westerly	70	72	23	84	51	355
West Greenwich	5	57	0	3	1	87
West Warwick	132	147	99	191	123	415
Woonsocket	414	90	150	572	220	356
Core Cities	*3,549*	*1,121*	*2,020*	*5,268*	*1,374*	*3,289*
Remainder of State	*1,367*	*2,578*	*2,638*	*1,988*	*1,060*	*7,002*
Rhode Island	*4,916*	*3,699*	*4,658*	*7,256*	*2,434*	*10,291*

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Table 21.

Child Care for Children Under Age 6, Rhode Island 1998

CITY/TOWN	POTENTIAL CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE	REGULATED CHILD CARE SLOTS FOR CHILDREN UNDER AGE 6	SLOTS PER 100 CHILDREN <6 IN NEED OF REGULATED CHILD CARE
Barrington	314	359	114
Bristol	591	229	39
Burrillville	481	123	26
Central Falls	721	150	21
Charlestown	166	47	28
Coventry	775	372	48
Cranston	1,543	1,403	91
Cumberland	660	288	44
East Greenwich	182	593	325
East Providence	1,296	946	73
Exeter	167	68	41
Foster	109	70	64
Glocester	270	78	29
Hopkinton	189	35	18
Jamestown	98	85	86
Johnston	531	462	87
Lincoln	423	400	94
Little Compton	86	0	0
Middletown	480	526	110
Narragansett	336	180	54
Newport	664	347	52
New Shoreham	25	0	0
North Kingstown	606	585	97
North Providence	633	347	55
North Smithfield	186	67	36
Pawtucket	2,483	1,040	42
Portsmouth	395	192	49
Providence	5,658	4,297	76
Richmond	174	84	48
Scituate	262	142	54
Smithfield	369	437	118
South Kingstown	480	475	99
Tiverton	300	226	75
Warren	329	145	44
Warwick	1,752	1,999	114
Westerly	579	450	78
West Greenwich	93	144	154
West Warwick	713	661	93
Woonsocket	1,397	596	43
Core Cities	*10,923*	*6,430*	*59*
Remainder of State	*15,596*	*12,218*	*78*
Rhode Island	*26,519*	*18,648*	*70*

Source of Data for Table/Methodology

The denominator is the potential number of children in need of regulated care, see methodology on page 84. The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December, 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References for Indicator

[1,2,3,4,5,6] *Early Childhood Care and Education: An Investment That Works* (1995). Washington, DC: National Conference of State Legislatures.

[2] Shore, R. (1997). *Rethinking the Brain.* New York: Families and Work Institute; and, *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[3] Zill, N., Collins, M., West, J., & Hausken, E.G. (1995). "Approaching Kindergarten: A Look at Preschoolers in the United States". Young Children 51 (Nov. 1): 35-38.

[4,5,6,7] Culkin, M.L., Groginsky, S. and Christian, S. (December 1997). *Building Blocks: A Legislator's Guide to Child Care Policy.* Denver, CO: National Conference of State Legislatures.

[5] U.S. Bureau of the Census, Current Population Survey, 1994 to 1998 average.

[6] U. S. Bureau of the Census, 1990 Census of Population.

[7] Casper, L. (1995)."What Does it Cost to Mind Our Pre-Schoolers?" In *Current Population Reports.* P70-52. Washington, DC: US Bureau of the Census.

[8,9,10,11] Calculations by Rhode Island KIDS COUNT based on data from the Rhode Island Department of Human Services (December 1998), the U.S. Bureau of the Census (1990), and Options for Working Parents (December 1998).

[12,13] Lopez, E.M. (1997). *Quality in Family and Child Care Partnerships.* Cambridge, MA: Harvard Family Research Project.

[11] Rhode Island Department of Human Services, INRHODES Database, December 1998.

[11] *Years of Promise: A Comprehensive Learning Strategy for America's Children.* (September 1996). New York: Carnegie Corporation of New York.

[11] Data from Rhode Island Head Start programs, December 1998. Calculations by Rhode Island KIDS COUNT.

Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible 3 and 4 year old children enrolled in the Head Start preschool program as of October 1, 1998.

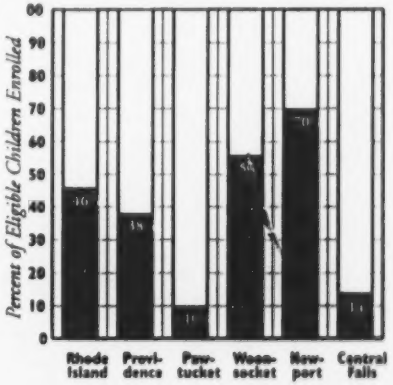
SIGNIFICANCE

Head Start is a comprehensive early childhood development program for low-income preschool children and their families. The program seeks to not only assist children in low income families but also to help their parents achieve self-sufficiency. Most children in the program attend for one year and are four years old.[1] Children living in families with incomes below 100% of the federal poverty line are eligible for Head Start. Up to 10% of the children can have a family income above the poverty line, especially if the child has a special need.

The Head Start program is designed to provide low-income children with the socialization and school-readiness skills they need to enter public schools on an equal footing with more economically advantaged children.[2] Participants in quality early childhood programs demonstrate a stronger commitment to school, have better relationships with their peers, and exhibit better classroom behavior.[3] They are less likely to be held back in school or to be placed in special education classes.[4] They are more likely to be successful in school and to graduate, to have higher earnings and less welfare dependency, and to report fewer arrests and out-of-wedlock births.[5]

Recent reauthorizations of Head Start at the federal level place high priority on increasing quality, expanding to serve a greater percentage of eligible children, enhancing access to comprehensive services for all low-income children, extending services to full-day and full-year, and strengthening collaborative efforts between Head Start and providers of child care and early education services.[6,7]

Percentage of Eligible 3 and 4 Year Olds Enrolled in Head Start, Rhode Island and Core Cities, 1998



Total number of children enrolled is 2,434.

Source: Calculations by Rhode Island KIDS COUNT based on data from the Rhode Island Department of Human Services and Rhode Island Head Start programs.

Low-Income Children Benefit from Comprehensive Programs

◆ Children in poor families have a greater need for more comprehensive and high quality child care and early education services. Studies show that children in poor families are nearly one-third more likely to suffer either from delays in growth and development, a learning disability, or a significant emotional or behavioral problem.[8]

◆ Comprehensive early childhood programs (such as Head Start) provide a developmentally-appropriate education program for children; provide or connect families to health, dental, mental health, and social services; involve parents in the program; and provide access to a wide range of community services that are responsive to family needs.[9,10]

◆ There are significant long-term cost savings associated with quality early care and education programs, particularly for disadvantaged children. The High/Scope Educational Foundation reported in 1993 that for every dollar spent on a comprehensive pre-school program for disadvantaged children, society saves $7.16 in welfare expenditures, justice system and crime-victim expenses, and overall schooling costs (due to fewer grade retentions and special education placements).[11]

◆ In 1996, only 41% of 3 to 5 year-olds whose families had incomes below the poverty line were enrolled in early care and education programs in the U.S. compared to 58% of children whose families had incomes above the poverty line. Hispanic children were the least likely to participate in early childhood programs in the two years preceding kindergarten.[12]

Early Head Start

◆In response to research indicating that the period from birth to age three is critical to healthy growth and development and later school success, Head Start now offers a program for pregnant women and their infants and children up to age three. In Rhode Island, 291 families receive services through Early Head Start.

◆The goals of the federally-funded Early Head Start program are to enhance children's physical, social, emotional, and cognitive development; enable parents to be better caregivers of and teachers to their children; and to help parents meet their own goals, including that of economic independence.[13]

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Table 22: **Percent of Eligible Children Ages 3 and 4 Enrolled in Head Start, Rhode Island, 1998**

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	5	3	56%
Bristol	35	28	81%
Burrillville	26	42	100%
Central Falls	283	40	14%
Charlestown	12	4	33%
Coventry	63	41	65%
Cranston	206	194	94%
Cumberland	40	18	45%
East Greenwich	13	1	8%
East Providence	160	93	58%
Exeter	7	1	15%
Foster	5	0	0%
Glocester	9	10	100%
Hopkinton	18	11	61%
Jamestown	3	1	30%
Johnston	72	39	54%
Lincoln	30	18	59%
Little Compton	1	5	100%
Middletown	26	37	100%
Narragansett	27	18	66%
Newport	194	136	70%
New Shoreham	2	0	0%
North Kingstown	56	44	79%
North Providence	92	41	44%
North Smithfield	6	3	50%
Pawtucket	589	60	10%
Portsmouth	11	11	97%
Providence	2,386	918	38%
Richmond	9	3	35%
Scituate	11	1	9%
Smithfield	11	4	35%
South Kingstown	28	24	86%
Tiverton	17	29	100%
Warren	32	23	71%
Warwick	203	138	68%
Westerly	62	51	82%
West Greenwich	3	1	30%
West Warwick	145	123	85%
Woonsocket	395	220	56%
Core Cities	***3,866***	***1,374***	***36%***
Remainder of State	***1,447***	***1,060***	***73%***
Rhode Island	***5,293***	***2,434***	***46%***

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled on October 1, 1998; U.S. Department of Health and Human Services, Region I, Administration on Children, Youth and Families; and Rhode Island Department of Human Services INRHODES Database, December 1, 1996-1998.

The denominator is the estimated number of eligible children based on a three-year average of the number of three- and four-year-old children in families receiving AFDC or FIP at a single point in time during each of three years: 1996, 1997, and 1998. This is an underestimate of children eligible, because it does not include children eligible for Head Start who live in non-AFDC/non-FIP families living below the poverty line. Therefore, the actual percentage of eligible served is likely to be lower than shown here.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1] *The Future of Children: Long-Term Outcomes of Early Childhood Programs* (1995). "Head Start". (Vol.5, No. 3). Los Altos, CA: Center for the Future of Children, The David and Lucille Packard Foundation.

[2] *The State of America's Children Yearbook: 1995* (1995). Washington, DC: Children's Defense Fund.

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[4,5] Schweinhart, L.J., Barnes, H.V., and Weikart, D.P. (1993). *Significant Benefits: The HighScope Perry Preschool Study Through Age 27* (Monographs of the High/Scope Educational Research Foundation, 10). Ypsilanti, MI: High/Scope Press.

[6,11] U.S. Department of Health and Human Services, Administration for Children, Youth and Families.

[7,8] Calkin, M.L., Grogansky, S. and Christian, S. (December 1997). *Building Blocks: A Legislator's Guide to Child Care Policy.* Denver, CO: National Conference of State Legislatures.

[9] *America's Children: Key National Indicators of Well Being* (1998). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

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School-Age Child Care

DEFINITION

School-age child care is the number of licensed child care programs and slots for children ages 5 to 12. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

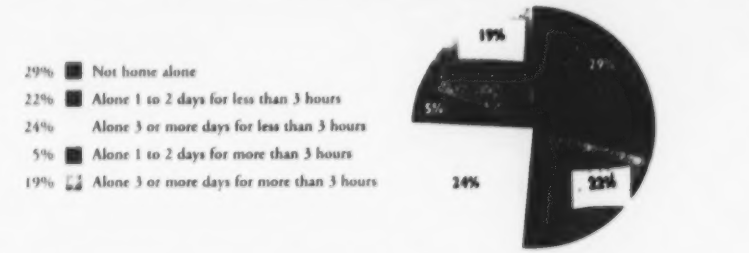
SIGNIFICANCE

Many parents need care for their school-age children during work hours. Children spend fewer than one-third of their waking hours in school.[1] Schools are typically open less than half the days of the year and in many cases are open only until mid-afternoon. Many children are alone during the hours before and after school. Older children are much more likely than younger children to spend time on their own.[2] Children who are without adult supervision when school is out are at significantly greater risk of truancy from school, emotional stress, receiving poor grades, substance use, sexual activity, and crime.[3] Children who spend more hours on their own and those who began self-care at younger ages are at increased risk.[4]

Children in well-designed after-school programs have better peer relations, emotional adjustment, grades, and conduct in school than their peers in other care arrangements.[5] When school is out, children and young adolescents need a safe place that does not simply duplicate the school day. They need access to a wide variety of enriching activities — homework and reading help, sports, music, theater, art — and the opportunity to build meaningful relationships with their peers and caring adults.[6] The out-of-school time activities that children engage in and the quality of adult supervision they receive are as important as family income and parents' education in determining academic success.[7]

In Rhode Island, the supply of licensed child care for children ages 5 to 12 has increased from 5,750 slots in 1995 to 8,652 slots in 1998.[8] Yet there continues to be a relatively low supply of before and after-school care relative to need. Parents find it particularly difficult to locate suitable after-school programs for middle school-age children (ages 11-14).[9] In 1998, Rhode Island financial barriers to after-school child care programs for elementary and middle school children have been reduced by making child care subsidies an entitlement for all families with incomes less than 200% of poverty ($32,900 for a family of four). The subsidies can be used for child care for children up to age 14.

Rhode Island Middle School Children, At Home After School without Adult Supervision, 1998


29% Not home alone
22% Alone 1 to 2 days for less than 3 hours
24% Alone 3 or more days for less than 3 hours
5% Alone 1 to 2 days for more than 3 hours
19% Alone 3 or more days for more than 3 hours
19%
29%
5%
24%
22%

◆ One in five (19%) Rhode Island middle school children (grades 6, 7 and 8) are home after school without adult supervision for more than three hours on at least three days a week. An additional 5% are home without adult supervision for more than three hours on one or two days a week.

◆ Middle school children left home alone for three hours or more report more depression, lower self-esteem, more behavior problems, and less academic success than children who were not left home alone for that length of time. Being home alone for three hours or more on even one day places children at higher risk than children who are home alone more frequently but for fewer than three hours.

◆ For children and youth without adult supervision, the out-of-school hours constitute high-risk time for high-risk behavior. Young people left on their own in the afternoon and evening hours stand a significantly greater chance of becoming involved in substance abuse, sexual activity, crime, and violence than their peers who are engaged in constructive, supervised activities.[10,11]

◆ Rhode Island middle school students from low-income families are less likely than students from high-income families to participate in extracurricular activities and programs. In 1998, 43% of low-income middle school children belonged to and regularly attended at least one extracurricular activity compared to 65% of high-income families.

Source: Robert D. Felner, PhD (1997). *Information Works! SALT Survey Reports: Measuring Rhode Island Schools for Change 1997-1998.* Providence, RI: University of Rhode Island, National Center on Public Education and Social Policy.

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Table 21

Licensed School-Age Child Care for Children Ages 5 to 12, Rhode Island, 1998

CITY/TOWN	COMMUNITY-BASED PROGRAMS	COMMUNITY-BASED SLOTS	SCHOOL-BASED PROGRAMS	SCHOOL-BASED SLOTS	TOTAL PROGRAMS	TOTAL SLOTS
Barrington	5	213	1	30	6	243
Bristol	2	30	2	90	4	120
Burrillville	1	38	2	83	3	121
Central Falls	1	49	2	112	3	161
Charlestown	1	18	0	0	1	18
Coventry	1	25	6	287	7	312
Cranston	7	183	6	224	13	407
Cumberland	1	25	3	140	4	165
East Greenwich	1	13	2	130	3	143
East Providence	3	150	10	427	13	577
Exeter	1	26	1	50	2	76
Foster	2	52	0	0	2	52
Glocester	0	0	1	75	1	75
Hopkinton	0	0	0	0	0	0
Jamestown	0	0	2	50	1	50
Johnston	2	44	1	39	3	83
Lincoln	0	40	2	45	2	85
Little Compton	1	20	0	0	1	20
Middletown	3	58	4	155	7	213
Narragansett	0	0	1	25	1	25
Newport	2	121	5	175	7	296
New Shoreham	0	0	0	0	0	0
North Kingstown	5	84	2	80	7	164
North Providence	1	100	1	25	2	125
North Smithfield	0	0	1	78	1	78
Pawtucket	4	348	3	152	7	500
Portsmouth	1	32	1	26	2	58
Providence	19	1,171	15	640	34	1,811
Richmond	0	0	1	25	1	25
Scituate	2	32	2	125	4	157
Smithfield	1	8	3	240	4	248
South Kingstown	1	18	6	245	7	263
Tiverton	1	20	0	0	1	20
Warren	1	100	1	50	2	150
Warwick	11	523	8	367	19	890
Westerly	4	133	3	140	7	273
West Greenwich	1	36	0	0	1	36
West Warwick	2	119	3	173	5	292
Woonsocket	3	189	3	131	6	320
Core Cities	***29***	***1,878***	***28***	***1,210***	***57***	***3,088***
Remainder of State	***61***	***2,140***	***76***	***3,424***	***137***	***5,564***
Rhode Island	***90***	***4,018***	***104***	***4,634***	***194***	***8,652***

Source of Data for Table/Methodology

All data are from Options for Working Parents, Greater Providence Chamber of Commerce, December 1998.

Number of licensed school-age child care programs and slots for children ages 5 to 12 as of December 1998. School-based programs are school-age programs located in schools and may be administered through the school district or a community organization (for example, YWCA, YMCA, etc.). Community-based programs are school-age child care programs located in the community, including child care centers, YMCAs, YWCAs, Boys and Girls Clubs, and other community organizations. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

References for Indicator

[i] [ii] *A Matter of Time: Risk and Opportunity in the Nonschool Hours* (1992). New York: Carnegie Corporation, Carnegie Council on Adolescent Development.

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[iv] Seligson, M. (1997). *School Age Child Care Comes of Age*. Wellesley, MA: National Institute on Out-of-School Time, Center for Research on Women, Wellesley College.

[v] Options for Working Parents, Greater Providence Chamber of Commerce, 1995 to 1998.

[vi] *CDF Reports* (November 1997). "After-School Time" (Special Report) Washington, DC: Children's Defense Fund.

[vii] *Safe and Smart: Making After-School Hours Work for Kids* (1998). Washington, DC: U.S. Department of Education and U.S. Department of Justice.

150

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151

Fourth-Grade Reading Proficiency

DEFINITION

Fourth-grade reading proficiency is the percentage of fourth-grade students who scored at or above the proficiency level for reading in the *New Standards English Language Arts Reference Exam in 1998*. The exam is made up of two parts: *Basic Understanding* focuses on the student's ability to comprehend and understand text, and *Interpretation and Analysis* focuses on the student's ability to correctly interpret and analyze text.

SIGNIFICANCE

Reading skills are critical to a student's success in school and in the workforce. Students who cannot read are more likely to be absent from school, exhibit behavior problems, have low levels of self-confidence, and perform poorly in school.[1] Parent education, language proficiency, family structure, and the community's socioeconomic status are strong predictors of student achievement in reading.[2,3,4]

Literacy begins long before children encounter formal school instruction in writing and reading. Parents play a significant role in shaping students' reading abilities by the reading practices and attitudes they convey at home, beginning in the early years.[5] Reading to young children at home and participation in pre-school programs are two factors that make a difference in reading achievement and overall success in school.[6]

A home environment which encourages learning and parents that are involved in their children's education are important factors in student achievement.[7] According to the National Education Goals Panel, children who report that they regularly read for fun on their own consistently outperform students who read only what is required of them at school. Children who regularly discuss their reading with family and friends score significantly higher in reading than students who report that they rarely or never do so.[8] Student reading proficiency declines as television viewing increases. Nationally, one out of five fourth graders watches six or more hours of television daily.[9]

Reading Proficiency, Rhode Island, 1998

◆ In 1998 in Rhode Island, 29% of fourth-grade students scored at or above the proficiency level for reading.

◆ The percentage of students scoring at or above the proficiency level ranged from high of 56% in Barrington to a low of 10% in Central Falls.

Source: RI Department of Elementary and Secondary Education, New Standards English Language Arts Reference Exam at Grade 4, 1998.

Reading Skill Development Begins at Birth

The long-term success of a child's learning and development depends on their health, safety, relationships, and experiences from birth through the early childhood years.

Birth to Three...

◆ Babies raised in safe and stimulating environments are better learners later in life than those raised in less stimulating environments.[10] In order to develop pre-reading skills, children need to have caring relationships with adults who listen and talk to them, tell stories, share books and music, and play with toys, crayons, and writing materials.[11]

Pre-School...

◆ Young children who attend Head Start, pre-kindergarten, or other center-based preschool programs have higher emerging literacy scores than other 4-year-olds. The benefit of pre-school attendance accrues to children from both high-risk and low-risk family backgrounds.[12]

Elementary School...

◆ Elementary schools that set high standards in learning and are committed to meeting those standards give children a better chance of leaving the fourth grade proficient in reading, writing, mathematics, and science.[13]

Family and Community Factors Influence Reading Skills

◆ Families with limited economic resources and parents who are not high school graduates are significantly less likely to read to their children every day at home and their children are less likely to attend a pre-school program in the two years before entering kindergarten.[14]

◆ In the U.S., Hispanic children face the most barriers to reading proficiency because they are more likely to be poor, less likely to attend pre-school, and more likely to have parents that have not finished high school.[15]

◆ Children's academic achievement is higher when they live in communities that provide supportive environments for parenting, provide access to high-quality early childhood programs, and have a variety of out-of-school learning opportunities for both adults and children.[16]

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Table 24

Fourth-Grade Reading Proficiency, Rhode Island, 1998

SCHOOL DISTRICT	% LOW-INCOME STUDENTS	COMMUNITY CONTEXT				% OF 4TH GRADE STUDENTS AT OR ABOVE THE PROFICIENCY LEVEL FOR READING
		% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	
Barrington	2.6%	88.9%	3,028	0.0%	3%	55.9%
Bristol-Warren	28.1%	NA	3,971	0.0%	2%	26.2%
Burrillville	20.6%	70.6%	2,990	0.3%	1%	29.3%
Central Falls	95.4%	46.9%	3,229	29.5%	65%	10.1%
Chariho	13.3%	82.2%	3,906	0.0%	3%	42.3%
Coventry	16.0%	74.4%	5,516	0.2%	3%	31.0%
Cranston	21.2%	74.0%	10,680	5.4%	12%	34.8%
Cumberland	13.2%	74.7%	4,822	2.7%	4%	39.3%
East Greenwich	6.0%	89.8%	2,268	0.4%	4%	40.9%
East Providence	32.9%	66.9%	6,757	7.4%	15%	32.5%
Exeter-W. Greenwich	12.5%	78.0%	2,090	8.5%	3%	23.1%
Foster	17.4%	81.9%	400	0.0%	0%	40.5%
Foster Glocester	7.7%	82.5%	1,497	0.7%	1%	NA
Glocester	18.5%	82.8%	875	0.0%	1%	41.0%
Jamestown	8.0%	89.0%	663	0.5%	3%	42.9%
Johnston	17.1%	66.8%	3,412	1.3%	5%	34.8%
Lincoln	10.6%	76.1%	3,516	1.0%	5%	34.5%
Little Compton	11.3%	86.0%	362	0.0%	0%	27.5%
Middletown	20.3%	85.0%	2,856	1.9%	13%	39.5%
Narragansett	14.4%	87.2%	1,861	0.8%	4%	49.4%
Newport	44.6%	84.1%	2,967	1.9%	32%	21.5%
New Shoreham	5.6%	94.0%	140	2.9%	6%	NA
North Kingstown	13.1%	86.2%	4,518	1.0%	4%	46.2%
North Providence	21.8%	70.8%	3,493	2.8%	9%	35.1%
North Smithfield	10.4%	71.5%	1,703	0.6%	2%	43.0%
Pawtucket	60.4%	61.6%	9,663	11.6%	36%	16.3%
Portsmouth	6.9%	86.3%	2,733	0.0%	5%	40.7%
Providence	78.7%	62.8%	25,611	20.1%	77%	11.0%
Scituate	9.4%	83.8%	1,764	0.0%	2%	34.3%
Smithfield	6.6%	80.8%	2,746	0.0%	2%	30.8%
South Kingstown	11.6%	85.5%	4,170	0.8%	9%	33.7%
Tiverton	19.4%	70.5%	2,208	0.0%	1%	44.6%
Warwick	18.6%	77.8%	12,075	0.7%	4%	31.8%
Westerly	18.8%	75.6%	3,540	0.3%	5%	28.1%
West Warwick	34.6%	70.3%	3,696	4.7%	10%	25.8%
Woonsocket	57.4%	56.2%	6,651	4.1%	30%	23.2%
Core Cities	*70.9%*	*NA*	*48,121*	*15.7%*	*59%*	*14.5%*
Remainder of State	*17.4%*	*NA*	*104,256*	*1.9%*	*6%*	*35.5%*
Rhode Island	*34.9%*	*72.0%*	*152,377*	*6.2%*	*23%*	*29.0%*

Source of Data for Table/Methodology

Low-income students are the percentage of students eligible for free/reduced price lunch in 1998.

Percent of adults completing high school are based on U.S. Bureau of the Census, 1990 Census of Population.

All other data are from the RI Department of Elementary and Secondary Education, 1998.

Core cities are Providence, Pawtucket, Central Falls, Woonsocket and Newport.

NA: Community has a regional high school.

References

[1] *Wasting America's Future* (1994). Washington, DC: The Children's Defense Fund.

[2] [3] *The National Education Goals Report: Building a Nation of Learners* (1995). Washington, DC: U.S. Government Printing Office.

[3] Zill, N., Collins, M., West, J., & Hausken, E.G. (1995). "Approaching Kindergarten: A Look at Preschoolers in the United States". Young Children 51: 35-38.

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[6] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[7] Shore, R. (1997). *Rethinking the Brain: New Insights into Early Development*. New York: Families and Work Institute.

[8] Fletcher, M.A., "Latinos at the Back of the Class," Washington Post (December 1998), based on a report by the National Council of La Raza.

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Children Enrolled in Special Education

DEFINITION

Children enrolled in special education is the number of children ages 3 to 22 who are enrolled in special education in Rhode Island elementary and secondary schools.

SIGNIFICANCE

The local school system is responsible for identifying and evaluating students ages 3 to 22 whom it is has reason to believe are students with disabilities and therefore might require special education and related services.[1] Children with disabilities are a heterogeneous group, varying by type of disability and age of the child, as well as by the many differences in the population at large — such as family income, race, ethnicity, primary language, and parents' educational level. Children with the same disability, in roughly the same degree of severity may vary tremendously in personality, motivation, social and family support systems, and compensating strengths.[2]

While there are wide variations in the specific needs of each child, there are some issues of common concern to families of children with disabilities.[3] Most children with disabilities have a limitation caused by one or more chronic physical conditions, cognitive conditions, or significant impairments in social, emotional or behavioral functioning in comparison with their peers of the same age.[4] Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, parent support, child care, recreation, and career preparation.[5]

Children with disabilities need access to health care that is appropriate to their special needs.[6] Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the Supplemental Security Income (SSI) program. A recent survey of the caretakers of the 4,314 children with disabilities enrolled in fee-for-service Medicaid found that over half (53%) of the children had two or more disabilities; 50% needed help with their personal care; 74% were limited in the kind or amount of activity they could do; and 7% were unable to take part at all in age-appropriate activities.[7]

Some children with disabilities may require costly therapeutic and health care services, wheelchairs, or home modifications. Because many services are not fully covered by insurance, families from all income levels can incur serious financial burdens.

Special Education for Pre-School and School-Age Children with Disabilities

◆ The Individuals with Disabilities Education Act (IDEA) mandates that all children have available to them a free and appropriate education designed to meet their unique needs. Children with disabilities or suspected disabilities become eligible for special education services from their school district at age 3.[8]

◆ The Individualized Education Plan (IEP) is a requirement of the IDEA. The IEP is a detailed description of the exact steps which must be taken by the school district in order to provide a free and appropriate public education to the student.[9]

◆ The services described in the IEP must be provided in the least restrictive environment, i.e. to the extent appropriate to the child's needs, the child should receive special services in a setting that is integrated with other children, with and without disabilities. This is sometimes referred to as "inclusion" or "mainstreaming." However, the IDEA does not mandate inclusion unless it is appropriate to the needs of the child.[10]

◆ In the 1997-1998 school year, there were 28,558 Rhode Island children (19% of the student population) who received special education services. Of these, 54% were classified as learning disabled; 20% speech disorders; 7% behavioral disorders; 6% health-impaired; 5% developmentally delayed; 4% mentally retarded; and 4% other disabilities.[11]

Early Intervention for Children Birth to Three

◆ Under Part C of the Individuals with Disabilities Education Act, states are required to provide appropriate early intervention services to all children from birth to age 3 who are developmentally delayed or have been diagnosed with a physical or mental condition that has a high probability of resulting in developmental delay.[12]

◆ In 1998, the five Early Intervention programs in Rhode Island served 1,699 children ages birth to three who were developmentally delayed or at risk.[13]

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Table 25.

Children and Youth in Special Education, by Primary Disability, Ages 3-22, Rhode Island, 1997-1998

SCHOOL DISTRICT	TOTAL # OF STUDENTS	BEHAVIORALLY DISORDERED	MENTALLY RETARDED	ORTHOPEDICALLY IMPAIRED	HEALTH IMPAIRED	LEARNING DISABLED	SPEECH DISORDER	DEVELOPMENTALLY DELAYED	OTHER	TOTAL STUDENTS WITH DISABILITIES	% STUDENTS IN SPECIAL EDUCATION
Barrington	2,964	25	5	1	8	386	129	2	26	582	20%
Bristol-Warren	3,814	47	54	7	15	464	159	26	18	790	21%
Burrillville	2,890	68	29	0	47	265	122	30	9	570	20%
Central Falls	3,120	104	48	11	22	463	66	43	21	778	25%
Chariho	3,681	42	14	7	53	315	164	25	28	648	18%
Coventry	5,338	73	46	7	46	628	116	48	15	979	18%
Cranston	10,120	86	34	6	80	1,483	369	75	44	2,177	22%
Cumberland	4,733	104	38	6	172	284	258	46	39	947	20%
East Greenwich	2,188	25	5	4	45	167	89	12	22	369	17%
East Providence	6,560	91	65	4	174	406	350	33	31	1,154	18%
Exeter-W. Greenwich	1,991	38	8	3	97	95	116	9	11	377	19%
Foster	370	0	2	0	2	18	27	1	2	52	14%
Foster-Glocester	1,500	10	6	2	14	139	35	0	4	210	14%
Glocester	821	5	4	0	7	67	90	13	5	191	23%
Jamestown	824	5	4	3	12	73	27	1	7	132	16%
Johnston	3,328	30	18	2	47	485	174	35	15	806	24%
Lincoln	3,411	31	23	2	74	259	92	41	32	554	16%
Little Compton	482	4	3	0	3	47	24	2	1	84	17%
Middletown	2,641	33	14	0	38	262	129	13	13	502	19%
Narragansett	1,808	31	3	2	44	224	97	12	7	420	23%
Newport	2,882	44	14	9	11	457	101	55	10	701	24%
New Shoreham	137	2	0	0	0	10	11	0	0	23	17%
North Kingstown	4,233	30	9	7	11	467	193	27	12	756	18%
North Providence	3,397	38	15	3	69	313	180	28	11	657	19%
North Smithfield	1,640	25	5	2	45	130	63	6	12	288	18%
Pawtucket	9,380	191	146	14	71	816	375	128	43	1,784	19%
Portsmouth	2,661	26	8	2	41	196	184	11	17	485	18%
Providence	24,569	238	308	17	13	2,593	406	309	58	3,942	16%
Scituate	1,736	9	4	1	32	119	124	8	10	307	18%
Smithfield	2,671	10	7	4	36	203	137	13	11	421	16%
South Kingstown	4,237	69	17	3	35	412	222	19	24	801	19%
Tiverton	2,125	19	6	1	19	189	115	5	10	364	17%
Warwick	11,667	223	89	14	133	1,404	385	157	84	2,489	21%
Westerly	3,453	49	10	7	49	381	181	16	25	718	21%
West Warwick	3,599	64	15	4	11	413	166	22	13	708	20%
Woonsocket	6,302	132	113	4	171	716	240	65	50	1,491	24%
**State Run Schools*	*912*	*14*	*7*	*3*	*4*	*141*	*6*	*0*	*126*	*301*	*33%*
Core Cities	*46,253*	*709*	*629*	*55*	*288*	*5,045*	*1,188*	*600*	*182*	*8,696*	*19%*
Remainder of State	*101,932*	*1,326*	*567*	*107*	*1,463*	*10,445*	*4,534*	*736*	*684*	*19,862*	*19%*
Rhode Island	*148,185*	*2,035*	*1,196*	*162*	*1,751*	*15,490*	*5,722*	*1,336*	*866*	*28,558*	*19%*

**State run schools are Davies Vocational Technical School, Metropolitan Career Tech. and RI School for the Deaf.*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1997-1998 school year. Office of Special Education, June 30, 1998.

Number of students is the "resident average daily membership" as calculated by the RI Department of Elementary and Secondary Education.

Other includes deaf and blind, visually impaired or blind, multi-handicapped, autistic, and traumatic brain injury.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the number of students enrolled in the school district.

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[9] Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 1998.

[10] Rhode Island Department of Health, Division of Family Health, Early Intervention Database, June 30, 1998.

158

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159

High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of the ninth-grade class that is expected to graduate, based on the existing drop-out incidence among 9th, 10th, 11th, and 12th grade students. The rate is computed using fall enrollment data and the number of students who dropped out between October 2, 1996 and October 1, 1997. It is a four-year cumulative rate, and represents the probability of an individual student graduating from high school.

SIGNIFICANCE

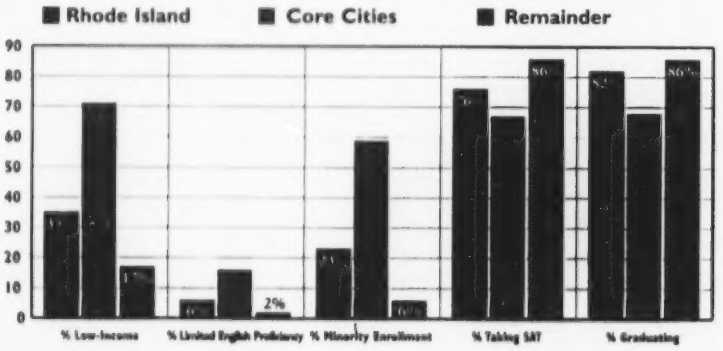
Children who receive a quality education are more likely to grow into capable, self-sufficient adults who contribute to their communities. Children and teens in economically disadvantaged communities are more likely to drop out of school.[1] Hispanic youth have lower high school completion rates than either black, non-Hispanic or white, non-Hispanic youth.[2]

Early warning signs for a student likely to drop out of school include inability to read at grade level, poor grades, frequent truancy, and behavior problems. Students can benefit from access to a broad range of community supports that address academic issues, health problems, inadequate nutrition, neighborhood and family violence, and other factors that can disrupt school performance.[4]

With the decline in manufacturing and the increased reliance on an information-based economy, education has become critical to a young person's success in the labor market. In 1997, students in the U.S. who dropped out of school earned $15,000 annually compared with $22,000 for a high school graduate and $38,000 for a college graduate.[5] The poverty rate for high school dropouts is ten times that of college graduates. Research shows that school completion and academic success increase children's ability to escape poverty, form strong families, and raise successful children of their own.[6]

Students may not achieve well in school for a variety of reasons; not necessarily because of differences in students' inherent ability to learn. Student achievement can be improved when schools have high expectations for all students; have effective and up-to-date curricula and teaching methods; prepared and sufficiently supported teachers; strong home/school linkages; adequate accountability systems; and effective and equitable allocation of resources.

Rhode Island Public School Students, Core Cities, Remainder of State, and Rhode Island, 1997-1998



Source: RI Department of Elementary and Secondary Education, 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

◆ Achievement differences among school districts, and among schools within a district, are correlated with the socio-economic status of the community or neighborhood. There are currently major contrasts in educational achievement and student outcomes depending on where a student lives and goes to school.[8]

◆ Social background factors such as limited English proficiency, family income, parent education, and family structure are associated with various levels of educational access and different educational outcomes.[9]

◆ Schools in low-income communities often have more limited access to up-to-date instructional materials, adequate classroom space, well-equipped libraries, laboratories, computers, and after-school sports and cultural activities.[10]

◆ Many children of color not only attend schools with fewer resources, but may also be confronted with low expectations. Research shows minority students are disproportionately assigned to special education classes and steered toward vocational education.[11]

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Table 26.

High School Graduation Rate, Rhode Island, 1998

	COMMUNITY CONTEXT						
	% LOW-INCOME STUDENTS	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	% OF STUDENTS TAKING THE SAT	1998 GRADUATION RATE
Barrington	2.6%	88.9%	3,028	0.0%	3%	85%	96%
Bristol-Warren	28.1%	NA	3,971	0.0%	2%	65%	80%
Burrillville	20.6%	70.6%	2,990	0.3%	1%	54%	88%
Central Falls	95.4%	46.9%	3,229	29.5%	65%	42%	44%
Chariho	13.3%	82.2%	3,906	0.0%	3%	50%	72%
Coventry	16.0%	74.4%	5,516	0.2%	3%	52%	87%
Cranston	21.2%	74.0%	10,680	5.4%	12%	59%	85%
Cumberland	13.2%	74.7%	4,822	2.7%	4%	62%	92%
East Greenwich	6.0%	89.8%	2,268	0.4%	4%	88%	96%
East Providence	32.9%	66.9%	6,757	7.4%	15%	60%	83%
Exeter-W. Greenwich	12.5%	78.0%	2,090	8.5%	3%	58%	88%
Foster	17.4%	81.9%	400	0.0%	0%	NA	NA
Foster-Glocester	7.7%	82.5%	1,497	0.7%	1%	61%	92%
Glocester	18.5%	82.8%	875	0.0%	1%	NA	NA
Jamestown	8.0%	89.0%	663	0.5%	3%	NA	NA
Johnston	17.1%	66.8%	3,412	1.3%	5%	45%	95%
Lincoln	10.6%	76.1%	3,516	1.0%	5%	69%	93%
Little Compton	11.3%	86.0%	362	0.0%	0%	NA	NA
Middletown	20.3%	85.0%	2,856	1.9%	13%	67%	95%
Narragansett	14.4%	87.2%	1,861	0.8%	4%	74%	93%
Newport	44.6%	84.1%	2,967	1.9%	32%	70%	86%
New Shoreham	5.6%	94.0%	140	2.9%	6%	100%	75%
North Kingstown	13.1%	86.2%	4,518	1.0%	4%	74%	91%
North Providence	21.8%	70.8%	3,493	2.8%	9%	42%	99%
North Smithfield	10.4%	71.5%	1,703	0.0%	2%	62%	94%
Pawtucket	60.4%	61.6%	9,663	11.6%	36%	55%	71%
Portsmouth	6.9%	86.3%	2,733	0.0%	5%	85%	90%
Providence	78.7%	62.8%	25,611	20.1%	77%	82%	68%
Scituate	9.4%	83.8%	1,764	0.0%	2%	61%	90%
Smithfield	6.6%	80.8%	2,746	0.0%	2%	64%	91%
South Kingstown	11.6%	85.5%	4,170	0.8%	9%	90%	81%
Tiverton	19.4%	70.5%	2,208	0.0%	1%	72%	90%
Warwick	18.6%	77.8%	12,075	0.7%	4%	65%	91%
Westerly	18.8%	75.6%	3,540	0.3%	5%	65%	88%
West Warwick	34.6%	70.3%	3,696	4.7%	10%	56%	76%
Woonsocket	57.4%	56.2%	6,651	4.1%	30%	44%	62%
Core Cities	*70.9%*	*NA*	*48,121*	*15.7%*	*59%*	*67%*	*68%*
Remainder of State	*17.4%*	*NA*	*104,256*	*1.9%*	*6%*	*64%*	*86%*
Rhode Island	*34.9%*	*72.0%*	*152,377*	*6.2%*	*23%*	*65%*	*82%*

Source of Data for Table/Methodology

% low-income students is the percentage of students eligible for free/reduced price lunch in 1998.

Percent of adults completing high school is from the 1990 Census of Population. All other data are from the Rhode Island Department of Elementary and Secondary Education, 1997-1998 school year.

NA: Community has a regional high school.

The denominator is the number of children enrolled in 9th, 10th, 11th and 12th grades in the Fall of 1997.

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Teens Not in School and Not Working

DEFINITION

Teens not in school and not working is the percentage of teens ages 16 to 19 who are not enrolled in school, not in the Armed Forces, and not employed. This indicator includes recent high school graduates who are unemployed, and teens who have dropped out of high school and are jobless.

SIGNIFICANCE

Dropping out of school and not becoming part of the workforce places teens at a significant disadvantage as they transition from adolescence to adulthood. These adolescents have a difficult time getting connected to the job market as young adults and have a less stable employment history than their peers who stayed in school or secured jobs.[1,2] They are at significant risk for teen parenting and criminal activity.[3] They are likely to lack credible references, have little confidence in their abilities, and lack knowledge about job opportunities.[4] Ongoing relationships with caring adults and connections within the family and community are powerful factors in protecting young people from negative behaviors, encouraging good social skills, responsible values, and positive identity.[5]

Many school and community programs do not adequately address the needs of students on the verge of dropping out of school and out-of-school youth.[6,7] All youth need opportunities to develop basic skills, such as math, reading and writing, as well as to develop other qualities that will help them to find a job, including problem-solving, creativity, self-motivation, and responsibility.[8] For those likely to drop out of school with no connection to the job market, school-linked part-time jobs can be an important resource to prevent dropping-out, reinforce learning in school, and develop positive work attitudes and habits.[9] The most effective of the current generation of school-to-work programs have positive effects on students attitudes toward work, school attendance, and drop-out rates.[10]

Connecting Youth to School and Work

◆ In 1996, almost one in ten (8.7%) Rhode Island teens ages 16 to 19 were neither enrolled in school nor working.[11] This group of teens are at especially high risk for teen parenting, crime, negative behaviors, and limited economic prospects.[12,13]

◆ In 1998, almost one in five (18%) Rhode Island teens dropped out of high school before graduating.[14] Teens are most likely to drop out when they do not succeed in school activities and see little connection between academic success and the challenges in their daily life.[15]

◆ Safe places in the community that offer productive activities for teens can connect youth to caring adults, strengthen teens' commitment to school, and provide opportunities for young people to contribute to their community and society.[16]

◆ Marketable skills attained through effective education help make a successful transition from school to work. A combination of basic skills, such as math, reading and writing, and other skills such as problem solving, creativity, self-motivation, and responsibility enhance readiness for work.[17]

◆ Work experiences connected with school can be an important mechanism for building on the interests of at-risk students and engaging them in school-related activities.[18]

◆ At-risk teens often do not have supportive relationships with adults who can help them access employers and places of employment. Effective youth programs develop these connections between at-risk youth and supportive adults.[19]

Table 27. **% Teens Not in School and Not Working, Ages 16-19, Rhode Island, 1990**

CITY/TOWN	TOTAL NUMBER OF TEENS AGES 16-19	JOBLESS HIGH SCHOOL GRADUATES	JOBLESS NON-HIGH SCHOOL GRADUATES	TOTAL NUMBER OF JOBLESS TEENS	% OF TEENS WHO ARE JOBLESS
Barrington	800	8	17	25	3.1%
Bristol	1,703	43	34	77	4.5%
Burrillville	886	33	31	64	7.2%
Central Falls	931	35	100	135	14.5%
Charlestown	261	0	0	0	0.0%
Coventry	1,689	59	52	111	6.6%
Cranston	3,500	119	304	423	12.1%
Cumberland	1,474	59	128	187	12.7%
East Greenwich	627	0	7	7	1.1%
East Providence	2,408	72	180	252	10.5%
Exeter	279	16	17	33	11.8%
Foster	232	16	3	19	8.2%
Glocester	565	27	27	54	9.6%
Hopkinton	377	10	44	54	14.3%
Jamestown	226	0	10	10	4.4%
Johnston	1,235	13	30	43	3.5%
Lincoln	874	32	17	49	5.6%
Little Compton	167	0	4	4	2.4%
Middletown	922	20	27	47	5.1%
Narragansett	653	15	16	31	4.7%
Newport	1,978	56	46	102	5.2%
New Shoreham	20	0	0	0	0.0%
North Kingstown	1,269	12	30	42	3.3%
North Providence	1,444	29	78	107	7.4%
North Smithfield	578	30	0	30	5.2%
Pawtucket	3,632	81	303	384	10.6%
Portsmouth	851	10	13	23	2.7%
Providence	12,841	254	1,042	1,296	10.1%
Richmond	284	18	16	34	12.0%
Scituate	555	24	10	34	6.1%
Smithfield	1,625	21	16	37	2.3%
South Kingstown	3,818	15	7	22	0.6%
Tiverton	812	34	24	58	7.1%
Warren	505	0	37	37	7.3%
Warwick	4,231	151	198	349	8.2%
Westerly	992	10	108	118	11.9%
West Greenwich	211	15	0	15	7.1%
West Warwick	1,478	46	89	135	9.1%
Woonsocket	2,357	101	285	386	16.4%
Core Cities	***21,739***	***527***	***1,776***	***2,303***	***10.6%***
Remainder of State	***37,551***	***957***	***1,574***	***2,531***	***6.7%***
Rhode Island	***59,290***	***1,484***	***3,350***	***4,834***	***8.1%***

Sources of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of teens ages 16 to 19 according to the 1990 Census of Population.

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Methodology and Acknowledgements

Methodology

The 1999 Rhode Island KIDS COUNT Factbook examines thirty indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The information on each indicator is organized as follows:

- ***Definition:*** A description of the indicator and what it measures.
- ***Significance:*** The relationship of the indicator to child and family well-being.
- ***Sidebars:*** Current state and national data and information related to the indicator.
- ***City/Town Tables:*** Data for each indicator presented for each of Rhode Island's cities and towns, the state as a whole, and the core cities.
- ***Core Cities Data:*** Five core cities are identified based on high child poverty rates: Providence, Pawtucket, Woonsocket, Newport, and Central Falls. These are the only Rhode Island communities in which more than 15% of the children live below the poverty level, according to the 1990 Census.
- ***Most Recent Available Data:*** The *1999 Factbook* uses the most current, reliable data available for each indicator.
- ***New Indicators:*** One new indicator "Children with Asthma" has been added to the twenty-eight indicators included in the *1998 Rhode Island KIDS COUNT Factbook*. "Homeless Children and Youth" has become two separate indicators: "Homeless Children" and "Homeless Youth".
- ***Modifications to Indicators:*** "Children with Disabilities" has been changed to "Children Enrolled in Special Education", "Out-of-School Time" has been changed to "School-Age Child Care", "Child Care" has been changed to "Infant and Pre-School Child Care", "Fourth Grade Reading Skills" has been changed to "Fourth Grade Reading Proficiency".

The *1999 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates, and/or percentages.

Numbers

The most direct measure of the scope of a problem is the count of the number of events of concern during a specified time period - e.g. the number of child deaths between 1993 and 1997.

Numbers are important in assessing the scope of the problem and in estimating the resources required to address a problem. Numbers are not useful to compare the severity of the problem from one geographic area to another or to compare the extent of the problem in your state with national standards. For example, a state with more children might have more low birthweight infants due to the larger number of total births, not due to an increased likelihood of being born low birthweight.

Rates and Percentages

A rate is a measure of the probability of an event - e.g. out of every 1,000 live births, how many infants will die before their first birthday?

A percentage is another measure of the probability of an event - e.g. out of every 100 births, how many will be born low birthweight?

Rates and percentages take into account the total population of children eligible for an event. They are useful in comparing the severity of the problem from one geographic area to another, to compare with state or national standards, or to look at trends over time.

Sources of Data and Methodology for Calculating Rates and Percentages

For each indicator, the source of information for the actual number of events of interest (the "numerator") are identified within the Source of Data/Methodology section next to the table for that indicator. For each indicator that uses a rate or a percent, the methodology used to estimate the total number of children eligible for the indicator of interest (i.e. the "denominator") is also noted within the Source of Data/Methodology section.

Rates and percentages were not calculated for cities and towns with small denominators (less than 500 for delayed prenatal care, low birthweight infants, and infant mortality rates and less than 100 for births to teens). Rates and percentages for small denominators are statistically unreliable. "NA" is noted in the indicator table when this occurs. In the indicator for child deaths and teen deaths, the indicator events are rare; in these instances, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Methodology for Child Care Indicator

The denominator is the potential number of children in need of regulated care and is computed by: a.) multiplying the 1990 Census number of children under age 6 with mothers in the workforce by 47% (the percentage of U.S. women with children under age 6 who use center-based care or family child care homes as their child care arrangement), and adding it to b.) the number of 1 to 5 year olds living in families enrolled in the Family Independence Program as of December, 1998 that has been multiplied by 50% (assuming half of FIP mothers will work), and then multiplied by 75% (the percentage of families receiving child care subsidies in Rhode Island who choose center-based care or families child care homes as their child care arrangement).

The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December, 1998. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data being collected. All data used in the 30 indicators were collected through the U.S. Bureau of the Census and through routine data collection systems operated by different agencies of the state of Rhode Island. We do not have estimates of the completeness of reporting to these systems.

In all cases, we used the most reliable data currently available. For census-based indicators, statewide numbers have been updated to 1996 using the current Population Survey, 1994-1998 average. The Current Population Survey does not provide data at the level of city and town. City/town tables, therefore, use information from the 1990 Census of Population.

We expect that over time the data used to assess child well-being in Rhode Island will be more timely and will contain more complete information on the state's racial and ethnic communities than is currently available.

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